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SOCIETY OF MEDICAL OFFICERS OF HEALTH

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## EDITORIAL

### Health of the School Child

We congratulate the Ministry of Education, its Chief Medical Officer, Sir John Charles, and Dr. Peter Henderson and his colleagues on the prompt appearance of "The Health of the School Child" report for the years 1950 and 1951,* which does so much to give it topical, rather than purely historical, interest. It is the intention of the C.M.O. to report on the years 1952 and 1953 as early as possible in 1954 and thereafter to consider a reversion to the former practice of an annual report. The onus is placed fairly enough on the School Medical Officers themselves, as the production of the Ministry's report in a reasonably short time after the end of the year depends on still more rapid preparation of the reports by individual S.M.O.s, extracts from which make the C.M.O.'s report so close a link with the field workers.

We should like to see this issue of "The Health of the School Child" made compulsory reading for all medical students and especially for post-graduates attending schools of social medicine and public health. The chapter on the School Clinic to some extent repeats and reinforces the excellent paper read by Dr. Henderson to the R.S.I. Health Congress at Margate in April last, and that on the School Nurse is an excellent statement of the scope and value of her work. In the chapter on the School Dental Service the agreement on a national level of public dental officers' salaries is described as a landmark, the effect of which has now been seen in the rebuilding of the service. The effectual combination of inspection and treatment in the organised School Dental Service associated with the educational system is clearly preferred to the more individualistic method of the general dental service.

A most useful chapter on Growth and Nutrition of the School Child summarises the "cross-sectional" and "longitudinal" studies now in progress and the various methods of recording growth in use at present. The usefulness or otherwise of weighing children is discussed, leading to the suggestion that more frequent weighing is often necessary to get significant records.

A special inspection of open-air schools conducted by the Ministry's medical officers is recorded with some adverse findings on the shabby austerity of certain schools which have received much Press notice.

* (Pp. 144. Price 5s. net.) London: H.M. Stationery Office.

### The Young Delinquent

"The Young Delinquent in his Social Setting" * is a valuable study by Dr. T. Ferguson, Professor of Public Health and Social Medicine in the University of Glasgow, and gives a detailed review of the environmental circumstances of a sample, numbering 2,139, of Glasgow boys; what might be called their crime history in relation to their environment, from the eighth to the 18th birthday, is set out in considerable detail, and it is sad to record that 289 of them counted 517 convictions between them during this period. The mentally handicapped had much the worst record, and even among the "ordinary boys" poor scholastic ability apparently predisposed to crime or perhaps, we might think, to being found out.

The influence of overcrowding, bad housing, broken homes, frequent change of work, temperamental factors, the presence of another convicted person in the family, attendance at church and cinema and other factors are discussed in detail with numerous tables and diagrams. The presence of bad company within the home quite clearly has a striking effect on encouraging juvenile delinquency, and the bad parent has much to answer for. The further study of boys whose offences are the first known in the family might yield pointers of equal significance. Whilst it is impossible, in surveys of this kind, to discuss the influence of the will in the individual, we must beware lest we accept the environment as the total cause of delinquency.

* (Pp. 158. Price 10s. 6d.) Published for the Nuffield Foundation by Geoffrey Cumberlege, Oxford University Press, London, 1952.

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The National Association for Mental Health announces its Annual Conference, 1953, on "The Practical Application of Research and Experiment to the Mental Health Field," to be held at the Victoria Halls, Bloomsbury Square, London, W.C.1, on February 5th and 6th, 1953. The conference will be opened by the Right Hon. Iain Macleod, M.P., Minister of Health, at 10 a.m. on Thursday, February 5th, after which Dr. G. R. Hargreaves, Chief, Mental Health Section, WHO, will speak on "Research and Mental Health." Prof. C. Fraser Brockington will be in the chair. General findings of the conference will be summed up by Prof. Brockington. The conference fee (including printed report) is 25s. 6d., and there are also day and sessional tickets. Applications should be addressed to the Conference Secretary, N.A.M.H., 39, Queen Anne Street, London, W.1.

# THE HOSPITALS' PART IN THE HEALTH SERVICE *

By A. Trevor Jones, M.D., M.R.C.P., D.P.H.,
*Senior Administrative Medical Officer,*
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Before advancing to the main theme of my discourse, let me thank the Branch for the honour of electing me its President. While I am no longer a Medical Officer of Health, as defined by statute, I am glad to be regarded as your colleague working to the same purpose, "not only to save life, but health" (Burn, 1947a).

The events of the past few years have perhaps crowded out the memories of those Medical Officers of Health who did so much to achieve this same purpose, and it might be profitable to turn back the pages of the history of the public health service and see how hospitals became a part of it. The first Medical Officer of Health in this country, Dr. William Henry Duncan, was appointed in Liverpool just over 100 years before the National Health Service Act came into force, and the story of the intervening years is nowhere better told than in the recent classic "History of Public Health" by another Liverpool medical officer, Prof. W. M. Frazer, to whom I gratefully acknowledge my indebtedness for much of the information in this paper.

It is significant that Duncan had been an honorary physician to the Liverpool Royal Infirmary, and, although engaged in curative work, turned his interest and great gifts to preventive work. The desperate needs of a people, living for the most part in a sordid and polluted environment, forced an emphasis on the prevention of disease. At that time, as now, this could only be satisfactorily carried out by public bodies with the authority of law, as Sir John Simon (who was the first Medical Officer of Health of the City of London) so aptly put it "under the Act grammar of sanitary legislation acquired the novel virtue of an imperative mood" (Burn, 1947b).

It is this imperative mood which permeated the long series of statutes which did so much to bring about the astonishing improvement in conditions during the latter half of the last century; after all, in this country at least, statutes are only an expression of public conscience, which was being gradually awakened by those who made it their duty to make diligent research into the causes of disease.

As far back as 1832, a Commission had been appointed to enquire into the working of the Poor Laws, and it could hardly fail to recognise that the solution of many of these problems was impossible without a drastic improvement in the health of the people—that, in fact, poverty and destitution were in part within the domain of public health (Frazer, 1950a). The changes in the habits of the people caused by the industrial revolution, and the distress left by the long Napoleonic Wars, had produced a social structure which, behind a facade of elegance, concealed the grim fact that over one-fifth of the population were in receipt of some form of parochial relief (Bryant, 1950). The Commission's report is of interest to us to-day, for the results are to be found in the Poor Law Act of 1834 and the Public Health Act of 1848. The former was responsible for the union of parishes and the erection of workhouses with their infirmaries, from which the municipal hospitals of to-day derive their origin, while the latter was truly responsible for founding the Public Health Service.

The involved and intricate story of public health legislation during the early part of the Victorian reign makes difficult but fascinating reading, and through it all one can observe the reluctance to impose central authority upon local responsibility; for as each Act succeeded the other, they seemed to increase the number and type of local authorities responsible for health administration. This was realised by the 'seventies, when the great new Acts laid down for a long time the pattern of health administration. The main principles underlining these Acts were (1) a strong central authority responsible to Parliament; (2) a system of local authorities each responsible for the whole of the public health and sanitary services of their areas; (3) finally, a consolidating Act of Parliament which brought together all the various and sometimes contradictory statutes which had been passed during the previous 30 or 40 years. It was, perhaps, inevitable but regrettable that some of these principles weakened as the century went on, particularly the principle that in each area there should be one authority performing functions in the field of health.

It was natural, too, that the emphasis in all this legislation and administration should have been on the side of prevention, for the dramatic successes in reducing communicable diseases justified this strong accent. It would certainly be wrong to criticise our predecessors for neglecting the organisation of concerted measures to deal with the healing of the sick, for curative medicine at that time was only emerging from the empirical efforts of the Middle Ages, and showed little to justify any confidence.

Nor was it surprising that there was no inducement at that time to go forward with the establishment of general hospitals, for they were not places which were without danger; with ignorant doctors and untrained nurses, it is probable that the admission of large numbers of cases would have added to the chances of death rather than reduce them. We had not then the advantages of antiseptics, anaesthetics, and scientific knowledge which make hospitals to-day the places of healing. There were then very few hospitals; some existed in London dating from the Middle Ages, and several with honoured names were established both in the provinces and in London during the 18th century. Boards of Guardians provided minimal attention for the sick paupers who were sent to the workhouse infirmaries, and under the 1875 Act local authorities had powers to provide hospitals; in practice, however, they were used only for the provision of "isolation hospitals" for people removed from their homes to avoid infecting others. Only towards the end of the Victorian era was there any substantial increase in the number of beds in general hospitals.

It must also be remembered that until 1858 high standards of practice of medicine were maintained only among a small band of teaching-hospital trained men. It was Sir John Simon who had much to do with the Medical Act that was passed during that year; this Act authorised a general medical council to keep a register of qualified medical practitioners and to have the duty of defining the qualifications and conditions in respect of general and professional knowledge, together with the course of study which entitled persons to be registered. It would be difficult to assess the value of this enactment upon the country generally, upon the profession and, especially, upon the hospitals where the new discoveries skilfully used by well-trained men allowed advances far into the unexplored field of curative medicine.

Another influence upon hospitals at this time which cannot be omitted from any account of the 19th century was the work of Florence Nightingale, who initiated such reforms in nursing and, indeed, in the whole design and administration of hospitals that she left her mark upon them not only in this country but throughout the world.

It is unfortunate that at the time when the voluntary hospitals were improving in efficiency and increasing in size and numbers, the poor law hospitals did not generally share in this movement, for by the end of the century and, indeed, during the early part of this, they were called upon to provide the bulk of the hospital accommodation for the working classes which then formed a larger proportion of the total population than to-day.

Perhaps the most unfortunate aspect was the continual separation of all forms of general hospital service (and, indeed, most curative treatment) from the organised health services, for although the local authorities could provide hospitals it was only for the sick who were dangerous to the community, *e.g.*, for fevers and mental patients. The result of this was that the only clinical interest normally available to Medical Officers of Health was in infectious

* Presidential Address to the Welsh Branch, Society of Medical Officers of Health, Cardiff, October 24th, 1952.

disease, and even there—in the absence of effective therapeutics—the accent was far more upon the prevention than upon the curative side. In spite of the fact that the central administration (from 1871, the Local Government Board) was concerned not only with health services but also with the poor law, there was no encouragement for the Medical Officer to interest himself in the medical attention given to the poor outside the workhouses nor inside the infirmaries. It seemed a pity that when "progress in medicine had conferred the power to cure or relieve a multitude of conditions which were beyond the scope of the profession a few years previously," that such great opportunities were withheld from the health departments.

Later on, in the early part of this century, the influence of medical progress could not be kept completely out of the workhouse infirmaries, and a few (but very few) Guardians were active in obtaining a high standard of medical service and nursing assistance, but, over a large part of this country, this hospital provision was far removed from the influence of health officers. More will be said about the fate of these workhouse infirmaries even after the transfer to the local authorities in 1929.

### Health Departments and Clinical Medicine

Up to the turn of the century the achievements in the realms of public health (then almost synonymous with preventive medicine) were, indeed, impressive. The control of sanitation, the supervision of water and food supplies, the inspection of dwellings and factories, aided by a gradual rise in the standard of living, had the effect of reducing the death-rate from 22·7 in 1851-55 to 17·7 in 1895-1900 and the mortality from tuberculosis from 3·6 to 1·9 (Frazer, 1950b), but there were indications that new fields were still to be explored, particularly in the health of infants, children, and the care of women in childbirth. The emphasis had shifted from environmental hygiene to the personal services, which by this time were undertaken largely by the new major authorities, the County and County Borough Councils (established under the Local Government Act, 1888). The linking of the school medical services with health departments of the major authorities was a step of the greatest importance, but in maternity, child welfare, the initiative was left to the local authorities, some of whom did important and progressive work. It was not until the 1918 Maternity and Child Welfare Act that any central impetus was applied.

These new responsibilities brought the health departments into clinical medicine for here, especially in the school health services, was an opportunity to study the beginnings of disease, and in the maternity services the health departments were responsible for attention to a patient. With the notification of tuberculosis, which commenced in 1912, the authorities assumed responsibilities (which, incidentally, they already had powers to do under the Public Health Acts) for the treatment of patients in dispensaries and hospitals, aided by grants from the Exchequer and benefits under the National Health Insurance Act. At the same time, schemes for the treatment of venereal disease were initiated and, by 1918, the V.D. Service had taken its place along the tuberculosis and child welfare service as a part of public responsibility. The effect of these services for personal health brought the preventive and curative sides closer together.

The treatment of illness in the home was, however, left outside the ambit of the health departments. Until 1911 this had been the care of an increasing number of private practitioners making up a profession gaining rapidly in strength and influence. The calamity of sickness in the home, especially of the wage-earner, had induced the establishment of many friendly societies and sick clubs, particularly in industrial districts. It was natural that the payments made by such clubs and societies to their members during sickness should be supplemented by arrangements made with medical practitioners to attend them and to provide the necessary certificates. The National Health Insurance Scheme followed this pattern and, in spite of much opposition, provided a domiciliary medical service for a large part of the population. The need for bringing in the Friendly Societies was probably the reason why this task was not given to the Health Authorities, for an entirely new kind of body — the Insurance Committee — was established.

It is, perhaps, easy at this distance to regret that another move forward was taken completely outside the existing health services, although the Act did state that the Medical Officer of Health might attend these Committees and give "advice and assistance" (Frazer, 1950c). (This is a provision, incidentally, not repeated in the Health Service Act, 1946, which makes no arrangements for Executive Councils —the successors of the National Health Insurance Committees—to have this "advice and assistance.") The great defect of the Insurance Act, however, was that no arrangements were made to provide hospital and specialist benefits, and these still continued to be provided to the population either by voluntary agencies or under the Poor Law. The working of the scheme has been admirably summed up by Newsholme (1936). "Had the National Health Insurance Scheme, after its introduction, been referred to a committee of persons expert in local administration in public health and medical work, along with the insurance representatives, it would have benefited immensely and much extravagant expenditure might have been saved. But the Act was made to work and it is certain that much good has been achieved through it." One of its best achievements was the establishment of a Medical Research Committee which was the forerunner of the present Medical Research Council.

### First Plans for a Comprehensive Service

Much thought was given at this time and after the first war to bring preventive and curative medicine together. To quote Newman (1928a), "The antithesis between curative and preventive medicine, which had been publicly suggested recently, is an entirely false antithesis. It is false administratively as it is false from the point of view of the science and art of medicine itself." This maxim had already been stated by the Dawson Committee (1920): "Preventive and curative medicine cannot be separated on any sound principle and in any scheme of medical services must be brought together in close co-ordination. They must likewise both be brought together within the scheme of the general practitioner services, whose duties should embrace the work of communal as well as individual practice." These are wise words which should be heeded as much to-day as on the day they were written.

The Dawson Report made far-reaching proposals for (*a*) Domiciliary services (doctors, nurses, midwives and health visitors); (*b*) primary health centres (staffed by general practitioners and visiting specialists); (*c*) secondary health centres (staffed by specialists), the whole to be linked with teaching hospitals. It is significant that the curative services of the secondary health centres should have as their nucleus the existing hospitals.

It is also interesting that a Welsh Consultative Council (1920-21) produced a separate report for Wales which makes specially stimulating reading; one of its recommendations was the setting up in it of a National Council of Health for Wales, which should have all the powers of local authorities, Boards of Guardians and insurance committees, acting through Regional Health Committees. The all-purpose health authority is hardly, therefore, a new idea!

In 1921 the Cave Committee vigorously defended "voluntaryism," but saw that the danger to the voluntary hospitals was their failure to work together in a co-ordinated scheme; the Sankey Committee in the following year emphatically stated that the continued existence of the voluntary system depended upon the voluntary hospitals forming themselves into a regionally organised association (Voluntary Services and the State, London, 1952a).

At that time the growing points of advances in medicine were the better voluntary hospitals. They also provided for the training of doctors, which was improving year by

year under the beneficent influence of the General Medical Council, but they were still completely outside any system of organised help either local or central. The need for hospital beds became more clamant as more was known about the ways disease could be treated, and although after the 1914-18 war the number of hospitals rapidly increased, their association with charity on the one hand and the poor law on the other continued.

Soon after the war it became quite obvious that most of the voluntary hospitals could not survive, much less grow, without regular drafts of financial help. This came neither from the central nor local governments, but from the people themselves in the shape of contributory schemes. Aided by such schemes, and the continuing but decreasing flow of voluntary subscriptions, they survived until the second world war, though still too far removed from other organised health services.

An opportunity occurred, however, in 1929. Under the Local Government Act of that year, the Poor Law hospitals were transferred with other Poor Law activities to the care of the counties and county boroughs and for the first time in history, the Medical Officer of Health had the responsibility for a hospital service on the one hand and a public health service on the other ; this gave an " opportunity for co-ordinating these transferred functions with the public health activities already exercised by the counties and county boroughs " (Newman, 1928b).

A few of the institutions which were taken over at that time were excellent hospitals, well equipped and sometimes quite well staffed, but these were exceptions rather than the rule. Many of them were large—they had to be —to make up for the lack of beds in voluntary hospitals, but too often they were regarded as a repository of the unwanted patients of the voluntary hospitals. They still laboured under the stigma of the Poor Law and it was not an easy task for the Health Committees to transform them into a service parallel and comparable with the best voluntary hospitals. Nor was this the whole story, for the transfer from the Poor Law was too often in name only, and many of the new public assistance committees only carried on the unhallowed work of the Boards of Guardians. It must be admitted, also, that there were difficulties. In many of the old workhouses it was impossible to differentiate physically the accommodation for the sick from that of the so-called able bodied.

Under the Local Government Act it was possible for these hospitals to be " appropriated," which meant that these places could be administered under the Public Health Acts. Where this happened the progress was more rapid, but the authorities were in trouble from the start, for they were handicapped by the financial crisis which developed in 1931 ; this led to the postponement of schemes for improvement, and it was not until 1934-35 that the new owners could advance boldly. As, however, they only had a few years before the next war came, only a few authorities were at that time able to match the best of voluntary hospitals.

In some places these hospitals, the Local Authority Hospitals, as they are now known, worked extremely closely with the voluntary hospitals. A special provision had been placed in the Act (Section 13) for the authorities to consult the Governing Bodies and Medical Staffs of Voluntary Hospitals in making their provisions. In a few places this consultation was extended and took the form of setting up Joint Hospital Advisory Boards. The whole object of this was, of course, to prevent overlapping and duplicating services, but in other places the consultation was hardly successful and did not prevent the setting up of parallel systems of two kinds of hospitals growing in rivalry which was too often unfriendly and antagonistic.

In 1936 the codification of all the best of the preceding Health Acts into the great Act of that year was seen, and with the exception of the general practitioner services, this omnibus statute covered the whole field. So far as hospitals were concerned it gave full authority to major authorities to establish them but it was, perhaps, inevitable that the permissive, rather than the imperative, mood was used.

### The Hospital Surveys

Most of the active steps taken by the local authorities, in co-operation in certain cases with voluntary hospitals, came to a full-stop at the outbreak of war, but the need for providing a large number of hospital beds for war casualties of all kinds became a national responsibility. In order to ascertain the amount of hospital provision in the country, the Emergency Medical Service of the Government carried out before the war several surveys which enabled us to get some idea of the amount and type of hospital provision available. The contents of these surveys have not been made public, but one comment can be quoted—that of the General Director of Emergency Medical Service, who wrote in 1939 :—

" Prior to the repeated surveys made by the Ministry of Health in the past 18 months, there was little appreciation of the low standard of hospital accommodation in the country as a whole, even those institutions that are wont to be regarded as the centre of enlightenment treatment and teaching in our large cities are with few exceptions either unsafe or woefully antiquated " (Titmuss, 1950a).

A retrospective assessment of the hospital provision in 1939 showed that we were short of hospital beds (excluding mental) by about one-third, or roughly nearly 100,000 beds in the country. In South Wales and Monmouthshire (Jones, Nixon & Picken, 1945) it was shown that out of a total of 7,945 beds, excluding tuberculosis and mental, nearly one-half were in premises unfit to be used as hospitals.

The results of all this showed clearly that the hospital service in this country was both in quantity and in quality far below standard, and the onset of war, with estimated needs for a million beds for casualties (Dunn, 1952) in the first few weeks (happily a gross over-estimate) presented the Ministry with an impossible task. Even by drastic evacuation of all but the completely bed-fast, the crowding of wards and even of ancillary rooms and corridors, the accommodation would have fallen far short. In addition to the shortage and the generally poor quality of hospitals, Titmuss (1950b) says :—

" The Ministry faced a rigid and conservative social constitution, first, on the one hand, existed a multiplicity of individualistic voluntary hospitals ranging from the great teaching hospitals to the small debt-ridden institutions, sometimes overproud of their operating theatre, but often short of surgical specialists ; secondly, on the other hand, there were the local authority hospitals, tied to out-worn boundaries, receivers of all the unwanted and uninteresting chronic cases, still flavoured with the stigma of poor law and often badly equipped and accommodated in large prison-like buildings. Somehow or other, the Ministry had to bring together these rival systems and create, out of the varying and independently provided hospital facilities, a national organisation for the care and treatment of air - raid casualties."

The war and the danger of aerial bombardment forced the Ministry of Health to introduce suddenly both regionalisation and decentralisation, together with a large measure of control of both voluntary and municipal hospitals (*Lancet*, 1939). The regions were based upon the Civil Defence regions, which were under the ultimate control of a Regional Commissioner, but the responsibility of hospitals devolved upon medical officers, specially appointed or seconded for the purpose. In London these officers were at first leading teaching hospital consultants, but assisted by medical officers from the public health departments. In the provinces, the county and county borough medical officers acted as the local agents of the hospital officers. This was an experiment in the regional idea, forced upon a country which up to that time had opposed all attempts at co-ordination in the hospital field. The service for the immediate attention of casualties, first-aid posts and ambulances was the responsibility of the major health authorities, and it was necessary that they should not only work closely together, but also very closely with the hospital services. The device of making the county

medical officer the agent of the Ministry's Hospital Officer was, therefore, of the greatest importance and the success of the casualty schemes generally (although it is fair to say that they were not severely tested until later in the war) certainly showed the strength of flexible administration, of which many of the local health departments were capable.

The E.M.S., as the war went on, found it necessary to cater not only for air-raid casualties, but for many other classes of patients. The policy followed was far from planned, but was one of compromise and adaptation. New schemes and special centres for treatment were adapted, the quality of hospital care improved and administration became more efficient (Titmus, 1951c). The pattern of regionally grouped hospitals with specialist centres was based upon a new idea, and for good or ill left behind lasting principles which have survived to appear again in the National Health Service.

It was during the war that the Minister of Health made a statement about the future of Britain's hospital services : " It is the objective of the Government, as soon as may be after the war, to ensure that by means of a comprehensive hospital service appropriate treatment should be readily available to every person in need of it " (*Hansard*, 1941), and it was announced that hospital surveys should be commenced immediately to provide for the information needed for future plans (Titmuss, 1950d).

Some of these surveys were carried out by the Ministry and some by the Nuffield Provincial Trust. They were published in 1945, and they brought some very unpleasant facts to notice, among which a few selected extracts will be of interest. The fundamental fact was that " there is no hospital system now " (Nuffield Trust, 1946). The surveyors contrasted the voluntary and local authority system and said that " the time is come when it should be possible to determine whether one system is better than the other, or whether both can be fused to produce something still better than either " (South Wales Area). They found that the local authority boundaries not only lead to uneconomical development but also act as barriers to admission, and " some of the shortcomings of the present services are traceable directly to unsuitable division of local government areas for hospital services. These lines cut across the natural flow of patients " (Sheffield and East Midland Area). This warning also applied to a similar danger from voluntary hospitals contributory schemes (Sheffield and East Midland Area). Such interchange between voluntary and municipal hospitals was not always smooth or conducive to happier relationships and in no area is there a genuine pooling of facilities in an attempt to extract from the combined resources the maximum advantage to the population (South-Western Area). It was suggested that consultants should play an important part in the clinic services of the district, which could be completely integrated with the hospitals (North-Western Area). There was a need for much greater co-operation between the hospitals and the home nursing services in the surrounding area (Sheffield Area), and the work of the district nurses could be more interesting and effective if it was in close association with the local hospitals and health centres which might well be their headquarters (South Wales Area). The association of the special services, such as maternity, child welfare and school medicine, with general hospitals was not nearly close enough (North-Western Area) ; with a co-ordinated hospital service it required a fleet of ambulances organised as part of the service (South Wales Area).

These selections are made from the various surveyors' reports, and there is no doubt that if some of them had their way, practically the whole of the medical services applied to the patient would be brought together in the hospital organisation. Many of the proposals, but not all, were incorporated into the National Health Service Act, 1946. The result of this has been the complete integration of all kinds of hospital and specialist services.

The great difficulty, of course, in such provision is the ultimate cost, not only in maintenance, but in capital. The experience of the war years, and since, has shown that the hospital costs have become so prodigious that some method has to be used to limit expenditure for, while investment in prevention returns a public dividend, it is not certain that such is the case in the treatment of ill-health. Herein lies one of the main differences between prevention and cure, for prevention is not only better than cure, it is also cheaper than cure (Winslow, 1951). Put in another way, cure is not only more expensive than prevention, but unsuccessful treatment or protracted cure is so much more expensive that only certain communities or individuals can afford it.

Perhaps if the hospital services had remained the responsibility of the local authorities, the cost would have been faced without question by some and refused by others, thereby producing an uneven balance according to the district, for the demands now made upon hospitals are greater than ever, for which there may be many reasons. According to Frangcon Roberts (1952), there are one or more alternative reasons for this greater demand for hospital and specialist, as well as general practitioner services. They are :—

(*a*) The conquest of disease may be more apparent than real and, as medicine advances, society may be setting itself an even higher standard of health.

(*b*) The advance of medicine is being outstripped by a real increase in the incidence of ill-health.

(*c*) Provision for the treatment of ill-health may be aggravated by social and other factors extraneous to the rational practice of medicine.

(*d*) The advance of medicine may paradoxically increase the incidence of disease.

The Act of 1946 was the result of many counsels and for that very reason perhaps was not likely to be immune from many criticisms. It has decided the great controversy between local authorities and voluntary hospitals by taking their functions away from both and placing them under the State. In doing so it extended some of the specialist services, particularly by making them available in the home. The local authorities have not only lost their hospitals but also practically all contact with clinical services. The general practitioner services, together with dental, ophthalmic and pharmaceutical work, are no longer provided by an insurance scheme, but are available to all, under the State ; but the administration is still to some extent local, and is performed by executive councils whose areas usually coincide with the counties and county boroughs.

Practically all purely clinical services are, therefore, the responsibility of the State, and the work left to the major health authorities is closely allied to the other social activities provided by these authorities. The Medical Officer of Health is therefore to-day more concerned with social than with clinical medicine. Health education, the care of the aged, nursing and other help in the home, the provision of health centres, the maintenance of health among school children, the transport of sick and injured—these and many others are now the main concern of the Medical Officer of Health and they all form part of the new scheme of social welfare which this country has accepted. They are really a widening of the Victorian concept of preventive medicine, for we have gone a long way beyond the relief of the destitute and the elimination of poverty. In environmental health, too, there are new responsibilities, particularly in housing and town planning, in which a medical officer has an interest.

It will be seen, therefore, that from the beginning the services designed to preserve health were many-sided ; even to-day there are distinct divisions which make themselves obvious to those who administer them. In the early days the emphasis was upon the important work which resulted in the prevention of so much communicable disease : that emphasis has given way to the provision of treatment, so that at present by far the larger part of the health service is the responsibility of hospitals and specialists. It might be thought perhaps that the hospital side has grown to such an extent that it is apt to over-

whelm and even overlook the other divisions, and that the interest of the clinician is more upon the case rather than upon the cause, upon the disease rather than upon the patient. The organisation is certainly becoming very complex and the complications make it very difficult to bring the hospital services into line with social medicine, environmental health and the practitioner services.

It is easy to propound the problem and the solution is as yet far from clear, but will probably be found when everyone working in each part of the Service will find out something about and appreciate the work that others are doing in other parts. It is right that the clinicians should know what the authorities are doing in social medicine, and that Medical Officers of Health should be aware of the movements within the hospital world ; the more we can bring the various workers together the better. It is not purely an administrative problem, nor yet a purely medical one, and we can still pay heed to the advice of men like Sir John Simon, who wrote many years ago of the pioneers who went forward, " some of them in lines of scientific study, others in lines of political principle, towards a day when statecraft and medical knowledge should sincerely take counsel together for the health of the people " (Simon, 1890).


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Mr. P. Arthur Wells, who has been deputy secretary and secretary-designate since April 1st, 1951, assumed the secretaryship of the Royal Sanitary Institute on January 1st, 1953, in succession to Dr. J. W. Dudley Robinson, who retired on December 31st, 1952. Mr. Wells also took office as secretary of the R.S.I. and Sanitary Inspectors Examination Joint Board, and as secretary of the National Nursery Examination Board on the same date. He holds the degrees of M.A., M.Sc., F.C.C.S., F.Inst.P., in science and in public administration, and was previously director of education to the International Wool Secretariat and general secretary of the Society of Dyers and Colourists.

## MONEY, MANPOWER AND THE NATIONAL HEALTH SERVICE*


By A. ELLIOTT, M.D., D.P.H.,
*County Medical Officer of Health, Kent*


The idea that the welfare of individuals was the concern or responsibility of the community had been recognised for certain groups of people and for certain special conditions for a very long period of our history. The extension of responsibility, however, to cover all members of the community, which is the basis of the modern Welfare State, was first put forward in a comprehensive form in the Beveridge Report of November, 1942. In the conditions that obtained in 1942 the Report had a propagandist use and value, both at home and overseas, which inevitably militated against its being a reliable blueprint for the future, and the times could scarcely have been less propitious for a cool and reasoned criticism of the fundamental issues of human behaviour upon which the Report was founded. It is, however, on the basis of the Report published at a time, as I have said, of great national stress, that the foundations of the Welfare State rest, that State having been brought into legislative life in July, 1948.

Our main concern with the Beveridge Report is in its references to the necessity in the Welfare State of a comprehensive National Health Service, and it is interesting to quote the exact words : " It is a logical corollary to the receipt of high benefits in disability that the individual should recognise the duty to be well and to co-operate in all steps which may lead to diagnosis of disease in early stages when it can be prevented." Reviewing the logic of this statement in light of events, we may, I think, ask ourselves how it is possible to prevent disease that has already occurred ; but I think we were probably blinded to a critical and logical examination of the proposals in the Report by the events of the time and by the magnificent prospect that was created by the Report's proposals.

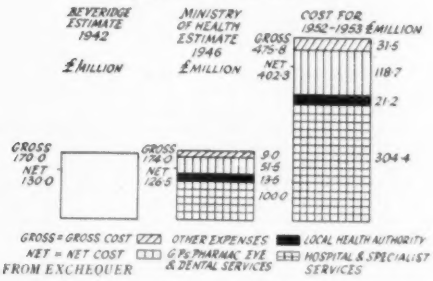
The financial proposals for the creation of a National Health Service in the Beveridge Report are, however, our direct concern and in 1942 for Great Britain it was estimated that the gross cost would be £170,000,000, of which £40,000,000 would come from the proposed National Insurance fund, that is, by a transfer from the payments that all wage earners would make, leaving £130,000,000 to be paid by the Treasury from general taxation. It is, however, noteworthy that the Beveridge Report estimated that the cost of a National Health Service would remain more or less constant and that the figure of £170,000,000 would still be the cost in 1965. The Report argued this assumption on the basis that a comprehensive health service would so improve the health and well-being of the nation that while expansion of facilities would occur the extent of use would decline. The road to administrative hell is paved with assumptions.

Our first task, therefore, is to look at the actual figures and see whether this assumption has been borne out in practice. Look at the chart showing what in fact has happened. The middle column showing the Ministry of Health estimate was prepared when the original National Health Service Bill was presented to Parliament in March, 1946. We may also note that an additional £10,000,000 a year has got to be found under the new Award for general practitioners. (See Graph I.)

I want to diverge here for a moment to examine very briefly the bases upon which modern civilisation rests. In any community, be it primitive or modern, man can only survive if he is fed, clothed, kept warm and has some protection against his enemies, whether they be internal or external. In a primitive community the meeting of these basic needs takes up the whole or practically the whole of the energies of the people, whilst in all countries that lay claim to a civilised way of life these basic needs have

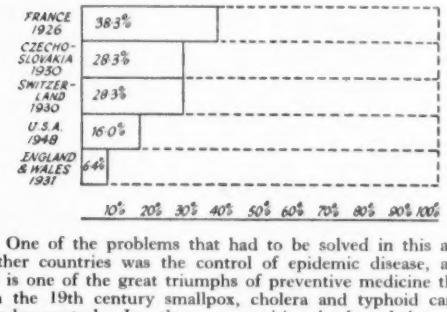
* An address to the County Medical Officers of Health Group (and Association of County M.O.H.s of England and Wales), July 18th, 1952.

GRAPH I
Cost of National Health Service




long since been met without absorbing the whole of the effort of the community. Those members of the community who are not needed in the struggle for bare existence can be used, and indeed are used, for the many other tasks and functions that go on around us. We can therefore conclude that if a country only just produces enough to keep its people fed, clothed and warm, it cannot be said to have enough resources to provide other things such as teachers, nurses, doctors, and so on, and hence we can see why it is that the so-called backward countries have no social services worth speaking about. Incidentally, you may be interested to see how many people in various countries devote their time to food production, England and Wales being well at the bottom, and that figure of 6·4% in 1931 is now 5·4% in 1950 for Great Britain. (See Graph II.)

GRAPH II
Percentage of population in various countries engaged in agriculture




One of the problems that had to be solved in this and other countries was the control of epidemic disease, and it is one of the great triumphs of preventive medicine that in the 19th century smallpox, cholera and typhoid came under control. In other communities the knowledge and technical application of methods to deal with malaria, yellow fever and other tropical disorders has opened the way to an extension of civilisation and the utilisation of resources, with a consequential raising of the standard of life, that is to say, life in those places has become more than a struggle merely to satisfy the basic needs I have described. Man is, however, surrounded by his enemies and the history of medicine has been, and always will be, the story of a struggle for life between man and those enemies. For preventive medicine the age of revolution in the conquest of major epidemics is over and new fields of prevention of disease that may yield similar triumphs have not yet manifested themselves.

What is the cost of the National Health Service?

The first point I must make is that the net cost from the Exchequer does not mean that those figures shown are the only costs that have to be found because, as you will realise, the money from the whole service has got to be found from somewhere, but the figure of £402,000,000 for the present year is of great importance because the ceiling beyond which the Treasury was not prepared to find the money was first introduced in 1949 by Sir Stafford Cripps. We must therefore realise that the money to be found for the National Health Service, and automatically, therefore, the resources it can command, has now been the subject of limitation for some years and that the service, therefore, cannot be regarded as comprehensive in the sense envisaged by the Beveridge Report, but only comprehensive in the sense that it is provided so far as possible for all within a budget that has now been limited. This is not an address on economics but it is necessary to point out that when we refer to the National Health Service as costing so many million pounds, we have got to think what those million pounds represent to the nation by way of resources. In this particular context those costs represent the absorption of materials and manpower to the extent of the total money given.

The basis of health is not primarily a matter of medical and nursing services but is essentially a matter of adequate provision of food, warmth and clothing. We may have the finest hospital and ambulance services in the world but unless at the same time we can maintain a supply of food which will ensure a reasonable standard of nutrition to everyone, we cannot be a healthy people. I would remind you that in Great Britain we can only grow enough food for half the population. The other half of the food that we require, even at our present levels of consumption, has to be brought from overseas and it has to be paid for in goods and services which we, as a nation, provide to those who grow and send us that food. I believe that to many people much of the present talk about financial crisis, the crisis in the balance of payments, dollar and gold reserves and so on is not fully understood, but the issue seems to be capable of simple expression in the phrase that at the present stage that half of the food supply we need, together with raw materials that we must have for our industries, is not being paid for by a sufficient production of goods and services in this country.

A point I shall be discussing later is that the number of men and women in this country who constitute the pool from which we recruit everyone who works is fixed. Every man and woman who is recruited from that pool to work in the National Health Service, or for that matter any other social service, such as education, has to be provided with food and the other basic necessities of life by someone who is engaged on productive work. It is true, of course, that every producer is a consumer, but it is obviously the case that not every consumer is a producer. We can, of course, say that in modern civilisation the services of many people who are not producers themselves are very necessary to the proper functioning of the producers, a simple illustration being the lorry driver who carries food from the farms to the markets.

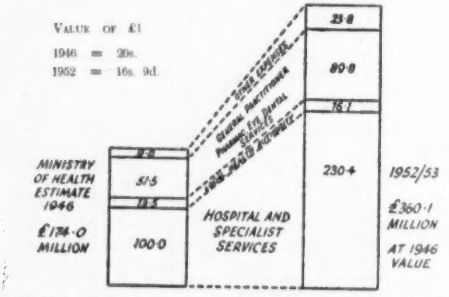
As I have explained, money can, as a broad generalisation, be regarded as a measure of the demand that the individual or organisation having it can make on the available resources of the nation and, bearing this in mind, let us examine briefly how the cost of the National Health Service is met. Part of the social legislation that came into effect in 1948 was the National Insurance Act and that provides for payments to be made by all paid workers (for example, I pay 5s. 1d., my employers pay 4s. 4d.) and the Ministry of National Insurance administers the tremendous funds that arise as a result of all of us who are working making payments of this sort. These payments are devoted to a variety of purposes, for example, sickness benefits, maternity benefits, and so on, but unfortunately it is very widely believed that the whole of the National Insurance contribution that an individual pays goes towards the National Health Service, and this is supposed by some people to justify a claim that having put so much in, they are entitled to draw so much out in the way of medical and other health services. In fact, only about 10d. of the 5s. 1d. goes to the National Health Service and we can say that, of the total figure of £475,000,000 that has got to be found next year for the National Health Service, only about £40,000,000 comes from the National Insurance fund. There are, of

course, the various payments that are made, for example, for private beds, local authority payments, civil defence, and so on, that reduce the gross cost of the service from £475,000,000 to just under £400,000,000 that has to be met from general taxation. Now general taxation simply means taxes that are levied for the general upkeep of the nation's essential services, such as the Navy, the Army, the Civil Service, and so on, and they, of course, affect every individual.

Why is it that the cost of the National Health Service is so widely different from the estimates of 1942 and 1946? When we consider the present figure of £475,000,000 we have to remember that that does not adequately reflect the cost of what would be a truly comprehensive service because if we had that the cost would certainly be far greater.

Since 1949 the Governments of the day have limited the cost to be met from general taxation to about £400,000,000 as representing the maximum that we can devote to the service from our resources of manpower and materials. First of all, of course, we must remember that there has been a depreciation in the value of money, that is, a pound now buys less in the way of resources than it did in 1946 and 1942. (See Graph III.)

GRAPH III
Cost of National Health Service in Great Britain




That, however, is not the whole of the story and we get complaints of extravagance in administration, in the supply of wigs and corsets and the provision of medical services to foreigners who may have suffered severe stomach injuries from English cooking. There may be extravagance in administration; it may cost £500,000 to provide wigs and corsets; it may cost a little to provide foreigners with medical care, but none of those things is really responsible for the wide miscalculations as to cost. A favourite argument is that the cost of the service shows the extent of the need that existed before the Act came into force and the corollary to this argument, therefore, must be that in some way or other continued expansion of the National Health Service must not be prevented as otherwise the need that has been disclosed is not being met in a comprehensive fashion. The difficulty about an objective assessment of this type of argument is to determine what true need is in a medical sense and whether it is imperative that every need that an individual has in respect of health services must, at all times and at all costs, be met by the community. We must also ask ourselves whether, in our own opinions, the enormous increase in the cost of the service has been truly reflected by a proportionate increase in the number of doctors, nurses and hospital beds that become available as compared with pre-1948 days, and I think the answer to that is that the proportionate increases in these facilities are well below the general increases in cost.

I believe that the true explanation of the cost and expansion of the National Health Service is to be met in the most cogent arguments put forward by Dr. Ffrangcon Roberts in his book "The Cost of Health." He points out that the Beveridge Report, in dealing with a comprehensive health service, was based upon a fallacy in believing that a comprehensive health service could make the population healthy and keep it so. It is a fundamental fact that human life survived for at least a million years without any form of organised medical services, but to-day we are, of course, not concerned with survival of life in that relatively primitive form. We are concerned far more with securing and maintaining in every individual the highest possible standard of health. Dr. Roberts, however, points out that the demands which a comprehensive National Health Service can make in money and manpower are illimitable because medicine is now closely integrated with science and science has no known boundaries nor is it likely, within any future that we can foresee, to have explored every possible field open to it. As you all know, we only stand at the gateway of the field of atomic physics. There are vast fields of research into the future antibiotics; chemico-therapy is still developing. All these fields are, however, ones that call for very great diversion of money and manpower for their fullest exploitation and I think we must, with reluctance, accept the fact that the limitations which are imposed by the very nature of human social organisation in the present stage of national and international organisation must slow down and restrict the fullest application in practice of the advances of medicine, now so closely allied to scientific enterprise. I think it essential to an understanding of the National Health Service in the modern Welfare State to look back at what was the position before 1948.

The national insurance system created by Mr. Lloyd George in 1911 provided that some 90% of the wage-earning population, but not their wives and children, paid a weekly contribution to insurance funds, their employers paid a somewhat similar contribution and the State contributed a small amount towards the cost of administration. Originally, in 1911, these contributions were only compulsory for wage earners earning below £160 a year; then the limit was raised to £250 a year in 1919, and later to £420, and that covered some 90% of the wage earners. In return for his weekly payments, the insured worker was entitled to general practitioner services, together with money payments when he was ill. The scheme was, however, an insurance one in the true sense of the term, that is, the total amount of money that was collected from the worker, his employer and the State was the total amount of money to provide doctors, medicines and money payments when he was sick. Some of the Approved Societies, through which the scheme was administered, had a little more money than others and were able to give additional benefits, for example, dentures, glasses and convalescent care, and this they could do because the amount of money produced from the three contributors was more than was necessary to provide doctors, medicines and sickness payments. That was an insurance scheme, and to paraphrase a popular phrase, the sky was not the limit in using it, the limit as to what could be drawn out being fixed by what was being paid in.

On the hospital side, local authorities provided services for which people had to pay according to their means. On the voluntary hospital side similar arrangements applied, except that those hospital authorities had no legal power to recover debts and were frequently running insurance schemes whereby, for the payment of a few pence a week, a contributor and his family were ensured hospital treatment when they needed it. In passing, I would say two things: the first is that I very much doubt whether, before 1948, anyone went without hospital treatment because they could not afford it; and secondly, the amount that members of the community were prepared to pay in the form of insurance schemes for securing hospital care was extremely small when compared with the amount they were prepared to pay for football pools, drinking and betting. There is a lesson to be learned from this second point and it is that when an individual was confronted with a choice as to how he was to spend his money, he did not, in the years before 1948, appear to value very highly the health service. Apart, therefore, from the National Health Insurance system whereby there was a legal sanction on employed

persons earning under £420 a year to make a contribution towards their medical care, the position before 1948 was that, in general, the amount of medical care that an individual chose to have was his own concern and unless he could prove his need under the Poor Law, he accepted financial responsibility for it. Since 1948, however, this responsibility of the individual has been almost entirely abolished so far as freewill payments are concerned. I say almost entirely because, as you know, the National Health Service never has been entirely free because certain parts of the local authority service have had to be paid for by those who had the means to do so, for example, the domestic help and recuperative or holiday home care under Section 28, and increasingly Part IV services are now the subject of charges.

It seems to me that for at least two years past the National Health Service has, in fact, been in the position that, in the opinion of two Governments of opposite political faiths, it has, in its demands on national resources and money materials, reached the level that cannot be exceeded for the present ; raising that level of expenditure of money would begin to absorb resources that are needed in other directions, for example, to supply us with an adequate amount of food, coal to keep us warm and the many other services such as education that have strong claims to a proper share of national resources. It seems, therefore, that we can sum up what we have already considered by saying that the National Health Service now faces a crisis in money expressed in terms of resources of manpower and materials and it would appear a reasonable assumption to say that this crisis has arisen because two things were not foreseen. The first thing that was not foreseen was the tremendous expansion that could take place in a health service because of the welding together of medicine and science, and the second thing that was not foreseen was how that expansion would be utilised once the main burden of providing medical care was transferred from each individual to the community as a whole.

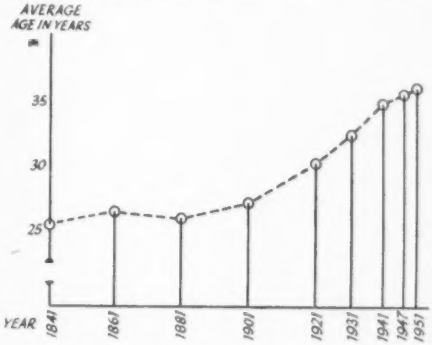
Now we cannot, and indeed must not, fail to recognise that since 1948 the National Health Service has provided a much better distribution of available resources for the diagnosis and treatment of illness, particularly in the hospital field. We must recognise that the unified nature of the organisation of the National Health Service under the Ministry of Health has brought about a far better deployment of available resources ; yet we are bound to recognise certain awkward facts about the deficiencies of the service and ask ourselves whether the gap between need and the provision is stationary, increasing or decreasing. The Ministry of Health tells us we are 29,000 nurses short and in the annual report for the year ended March, 1950, the Ministry goes on to point out the large number of beds that are empty by reason of this shortage. I do not need to tell you about the problems created by the shortage of staffed beds in sanatoria, mental hospitals, mental deficiency colonies and even the general hospitals—these are known. The question, however, which we must ask ourselves is, are we short of 29,000 nurses because of Governmental decisions to impose, to use the fashionable term, a ceiling on expenditure, or is it because the resources in terms of manpower and materials are not there ? To put it another way, what would happen if the Government suddenly decided to spend another £200,000,000 on the health service ? Would we then get our nurses, new hospital buildings, and so on ? My view is that if we did have another £200,000,000, we still could not provide a truly comprehensive service to satisfy everyone because the alliance of medicine and science would, I believe, foster development faster than the rate of development of resources to meet new needs. It seems to me that as a community we have not yet reached the stage where we are prepared to recognise and accept the fact that the State is only the individual writ large and hence the resources of the State are no greater than the resources that can be contributed by all individuals within the State. There is still the lingering belief that somewhere and in some fashion there is a hidden reservoir of money, resources and power that, by some Parliamentary feat of legislation, can be tapped to provide us with everything that we want to have.

Two new considerations now arise on manpower. The first is what is the availability of women for the midwifery and nursing profession now and in the next 10 years, and the second is what type of population have we got in Great Britain and what will be the demands of that population on the social services, including the National Health Service ? First of all we must recognise the fact that food is an essential to health and that half of our present population has to be fed by food grown by someone overseas. We must, therefore, remember that, in regard to the demands made for pairs of hands in any social service, the first essential is that these pairs of hands can be spared from the primary job of producing either food for half of us or producing something else that can be exchanged for foreign food to feed the other half. Without that basic fact borne firmly in mind, we cannot arrive at a true understanding of what the future task is in regard to the organisation of the social services.

However, to return to the question of what sort of population we have. The first point I must make is that we have a population in which the average age is steadily rising. (See Graph IV.)

GRAPH IV

The average age of the population, England and Wales

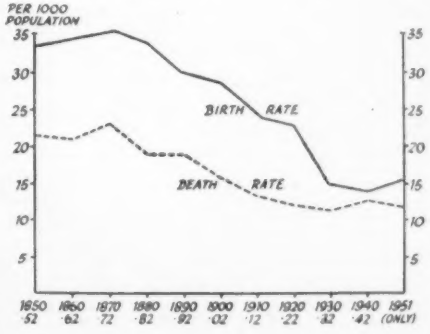



Our population has grown from 18,000,000 in 1851 in England and Wales to nearly 44,000,000 in 1951. The rate of increase is, of course, beginning to flatten out, and Graph V shows why that is so.

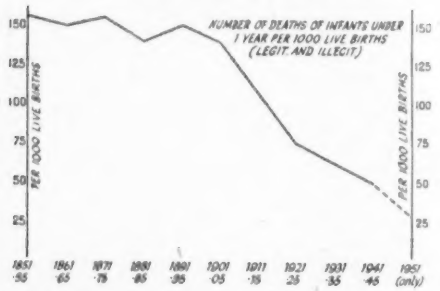
You see the birth-rate and the death-rate shown over the past 100 years and, very briefly, when those two rates come together, as they nearly did in 1940, that must result in a static population.

GRAPH V

Birth and death rates, England and Wales, 1851–1951



GRAPH VI
Infant mortality rates, England and Wales

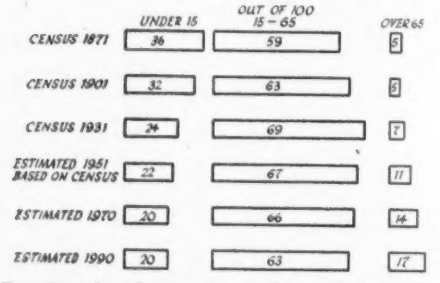



Graph VI shows the infant mortality rate over the past 100 years and you will see how that has been reduced.

Every child is, of course, a potential citizen and wage earner of the future and it is obvious that a series of events which resulted in such a sharp drop from 1901 onwards cannot result in giving us a large number of additional children in the future because the rate is now extremely low at 26 deaths under the age of one for each thousand live births and, in spite of everything we may do, it is never likely that we shall get to the state of never losing a single child under one. Each child up to the age of 15 at least is a dependant, that is, a person who requires to have his or her needs met without directly contributing himself or herself towards the resources of the country ; yet bearing in mind that the nation is immortal, even although the individuals who compose it are mortal, it is to this group of dependants that we look to carry on in the future and indeed, to put it on a selfish basis, to make provision for us in our old age. I make this point because, in our planning to-day it ought to be a duty upon us to see to it that we do not expend too many of our resources for immediate needs, but, as a direct expression of national policy, use some of those resources to build up for the next generation.

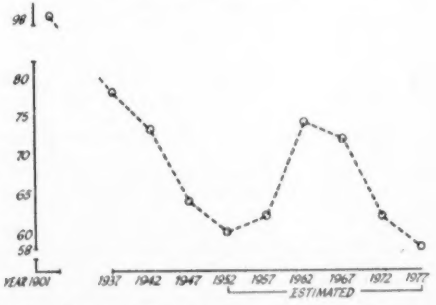
I come now, however, to Graph VII which, I think, is of the greatest importance and which shows the age distribution in England and Wales of three main groups of people.

GRAPH VII
Age distribution, England and Wales




For the sake of convenience, this age distribution is worked out over 100 people — those under 15 who are dependants—those between 15 and 65 who may be regarded as the pool from which we draw the bulk of our wage earners—and those over 65 who we would like to regard as being no longer called upon to work and who, as you well know, in many cases require care and attention. As a generalisation, we can say that it is the duty of those between 15 and 65 to work and look after the other two groups, that is, those under 15 and those over 65. Look at the position in 1901. There were then 63 people out of every 100 who were what we can call workers and there were 37 who, broadly speaking, were dependants. In 1950 there were 67 out of every 100 people who were workers ; 22 out of every 100 were under 15, but 11 were over 65. Now the significant feature about that series is that it is out of the left-hand group that the workers of the future are to come, and it is out of the age group of the workers that the old will come. Nothing that we can do can alter that figure of children and there is no immediate sign that in the next 10 years the number of children to be born is likely to be very much different from the number of children born in the past 10 years. I will not take you up to 1990, but let us look briefly at the figures for 1970. There the number of people over 65 has risen to 14 in each 100 and the number of children has dropped to 20 in each 100. What are the prospects facing the National Health Service in regard to the availability of workers to it ? In this country the Ministry of Labour tell us there are some 22,000,000 people working, which is 2,000,000 more than in 1939. Of this increase in numbers, just over half—in fact 1,075,000—are women and that means that 20% more women are employed throughout the country in industry, the professions and various services than there were before the war. Now out of that 20% increase, or just over 1,000,000, the professions have absorbed 160,000 women, mainly in the educational and health services. The interesting thing is that of these 160,000 increase in the number of women employed in the professions, nursing and midwifery have taken 50%, that is, 80,000. Just reflect on that figure for a moment because it means this : that before the war there were 160,000 women employed in nursing and midwifery and now there are 240,000. Whilst, therefore, there has been a 20% increase in the number of women employed since 1939, in the field of nursing and midwifery the increase has been 50% and it can, I think, be argued that the health services have had far more than their fair share. Now I mentioned just now that there is a shortage of 29,000 nurses and we must ask ourselves what would be the effect on the country's economy if those vacancies were filled. I am no prophet on economic events, but I think we must take the view that when to-day the urgent need is for more pairs of hands to produce more goods for sale abroad, it is unrealistic to claim that whatever happens elsewhere the health services must continue to claim greater numbers of those who are available for work. Graph VIII shows the number of girls between the ages of 15 and 19 and the trend for the future.

GRAPH VIII
Number of women (age-groups 15–19) per 1,000 female population, England and Wales




In Graph V, giving the birth-rates of the nation, one of the most significant features is the sharp drop that took place between 1920 and 1930 and the slower drop that took place between 1930 and 1940. Obviously a drop in the birth-rate means that, as fewer babies are born, 20 years later there will be fewer adults available for work. That drop in the birth-rate for some 20 years before the war means that, in the next 10 years, the number of women between 18 and 30 who will be available for employment will decrease by nearly 485,000. To put it another way, we are faced with

the position that until 1957, when we get some relief from the higher birth-rate from 1945 onwards, there will be 100,000 fewer girls reaching the age of 18 each year than there were in 1939. As you know, at the moment the country's schools are having to take in increased numbers of children who have now reached the age of five, these numbers having increased as a result of the birth-rate in post-war years. We demand smaller classes, which means more teachers, and at the same time nullify our efforts to recruit those teachers by emphasising the need for recruitment into nursing. These figures show us quite plainly that for the next 7 to 10 years, as compared with the past 20 years or so, there is going to be a serious shortage of young people and that will be particularly marked in the case of women.

Two grave factors therefore arise. The first is that the field of recruitment for all forms of women labour will be smaller than it has been in the past and will not begin to improve for another eight years and even then the improvement is not going to be marked. The second important grave factor is that the increase that has taken place in the number of nurses and midwives since 1939 must, of necessity, be slowed up very considerably simply because the women are not there to be recruited. We cannot, of course, neglect the fact that, taking a very wide view of our responsibilities in the field of health, we have to recognise that there is likely to be a further increase in the demands for women, and men for that matter, to work in the field of production if the nation is to increase its exports to obtain adequate food to maintain a reasonable standard of life. I believe it to be true that the National Health Service faces a crisis in womanpower in that it cannot now discharge all its commitments and that position is bound to deteriorate over the next few years simply because there were not enough girl babies born in the years before the war.

It is also, I think, of importance to recognise the fact that we have not only got to think about present needs but also the future needs of the nation and bear in mind that the primary function of women, in a biological sense, is the production of babies to carry on the future of the race. How far will the birth-rate be affected by the ever-growing demands for women in industry, professions and other services ?

Another important consideration that, although outside the strict ambit of the National Health Service, nevertheless has a bearing upon the number of people that can be employed in it, is the increasing work that has to be met in the care of old people. I have shown you a chart giving the increase in the average age of the population and we must recognise that, on an average, people to-day are living longer. One hundred years ago there was only one person over 65 for every 13 of the working population. To-day there is one person over 65 for every six of the working population and by 1977 the figure will be one in four. Compare that in 1861 there were 1,000,000 people over 65 and the fact that there will be 6,000,000 of at least that age by 1977. As you know, the Government is at present considering what can be done to keep old people in employment, and I think we must anticipate a raising of retirement ages, but, even so, the numbers of old people who will require some form of care and looking after by the younger members of the community must inevitably rise and these services, therefore, are going to compete for the recruits.

I can therefore sum up the second part of what I have said by saying that the National Health Service faces a crisis in the supply of womanpower.

While it is true that there is no such person as an average man or a man in the street, can we arrive at any conclusion about what the bulk of the population who are not employed in the National Health Service, but who stand to benefit from its operation, really think about these two problems ? I would hazard a guess that the ordinary individual has little knowledge of the manpower position and I would believe it to be true to say that the primary and overriding consideration with which most citizens regard the National Health Service is that when they or those nearest to them need medical, dental or other health services, they expect them quite naturally to be free and they want to see that the availability of those services is free of direct charge. No one in their senses could reasonably expect that citizens at large, having been promised a free and comprehensive National Health Service, are going to pay for the service out of their own pockets simply to transfer the burden from the community to them as individuals. The only appeal that can be made in present circumstances is to every individual's intelligence to use the service sparingly and only when it is urgently necessary, since the converse of this proposition is that if the service is used by everyone at all times and irrespective of whether it is really necessary, then the demands made in terms of manpower and resources are totally inadequate for that service to cover the needs that then arise. Yet can any of us, when faced with ill-health or the fear of ill-health in ourselves or those nearest to us, maintain a purely objective view as to the responsibilities that devolve on us in using a State service ; indeed, we can go farther and say that there is a direct encouragement in the free basis of the National Health Service to all individuals to seek its aid and services at the earliest possible date in order that they may be restored to full health, and hence to useful members of the community. We must, I think, accept the fact that expansion in any human activity, whether it be in the welfare services, State industry, private industry, or even in our own personal activities, cannot be achieved automatically and must be governed in direct proportion to the amount of materials and manpower that can be put into that activity. The State, in the National Health Service, can only provide the service according to the resources that can be made available and at present we are getting near the end of available resources in manpower. It is a matter for comment here that although we claim to live under a planned organisation, we have stopped short at planning what proportion of our manpower we can devote to the various enterprises that are undertaken in our state of civilisation. Everybody knows that we are short of nurses, dentists, coal miners, agricultural workers and so on, yet each of these shortages is considered as a separate matter. The present organisation that exists to deal with conditions of service in various forms of employment rests on the basis that a shortage in any particular field must be overcome by an improvement in pay and conditions · yet since there is no great reservoir of manpower that remains untapped, improvement in one field can only result in deficiencies elsewhere. When those deficiencies elsewhere become apparent, they are again considered in isolation and wages are improved to effect increased recruiting, and so we go on. Surely the time has arrived when there should be a critical examination of the National Health Service to determine what part of the national resources can be spent on it and what, in future years, should be its available resources in man and womanpower. Do not forget that nurses are not the only women working in the National Health Service and reflect upon the tremendous increases that have taken place in the number of medical auxiliaries. Is it not possible even now to reconsider how best we can provide a National Health Service that will meet all essential demands and yet determine what proportion of the women in the population, and for that matter a considerable number of men too, can properly be spared from all the other tasks of our civilisation to work in that service ?

If we look at what has been happening in the National Health Service over the last four years we see that two successive Governments have imposed charges for certain parts of it. The Labour Government introduced charges for dentures and glasses and the present Government has introduced charges for certain people for dental treatment and the charge of 1s. for prescriptions. What precisely is the significance of these acts ? It seems to me it is a tacit acceptance of the fact that some part of responsibility for

an individual's use of the health service is not to be borne by the nation as a whole but by that individual himself. In other words, speaking broadly, if an individual wants dentures, dental treatment, glasses or medicine, it is going to be his responsibility to pay some part of the cost and not, as was the case when the Act was introduced in 1948, having the whole of the cost transferred to the community as a whole.

I have spoken at length about the two crises that face the National Health Service—the supply of staff to it and the call it makes upon resources ; yet we must recognise that even in spite of the economic difficulties of the time, the essentials of the service, that is, the provision of what is essentially medical care, still remain free of direct cost. No one can prophesy whether future Governments will find it necessary to transfer still more of the burden of providing the cost away from the community as a whole to each individual as and when that individual's needs arise. I believe that it is inevitable that in future a choice has got to be made of what forms of treatment are going to be far too expensive for any individual to provide by himself and must be provided by the State, and what forms of care can be provided by the individual in that nothing essential to his health is being withheld from him if he is not prepared to make a financial sacrifice himself. I can, however, but hope that a little more discrimination will be used than at present because while it may be argued that if someone requires a denture or dental treatment and will go without rather than pay, we ought, I think, to look more seriously at the issue as to whether certain drugs that may be regarded as live-saving ought really to be the subject of charge. By all means make charges for medicines and drugs, such as aspirin and cough mixtures, that are not absolutely vital to the individual's recovery, but is it a good thing to make charges for things like penicillin and insulin that are of such proved efficacy that they are properly regarded as essential. Opinions must vary, but my conclusion is that the root causes of the difficulties under which the National Health Service is labouring have not yet been fully accepted and that the policy of charges which has been introduced, while no doubt essential in the present stage of our national economy, could have been applied in a different form. It is an unenviable task to survey the vast range of health services that are provided under the Act and to determine how, within the limits of national resources and manpower, we can concentrate upon those which are essential and hence can properly be regarded as a proper burden on the community, and those which are less essential and can be left to the individual's choice as to whether he pays for them or not. Yet I believe some such choice is necessary, since I have the gravest doubts as to whether it is possible in present circumstances so to educate the whole of the community that they will use the health service with such a discretion as to be able to limit their demands to such a level that once again we can return to the principle of an entirely free, and at the same time entirely comprehensive, service.

### Discussion

**Dr. Elliott,** in introducing his paper, remarked that for the past six months increasing economic pressure on the local authorities had caused them seriously to consider the limitation of their staffs. His own investigations in this connection had brought some striking facts to light, in particular relating to the availability of women for work in the social services. He had accordingly prepared the paper he was presenting some months previously and had subsequently modified it on perusal of Dr. Ffrangcon Roberts' book, "The Cost of Health." The facts given in his paper regarding manpower and money were from official sources, but the deductions were his own and he welcomed the opportunity of putting them before his colleagues.

The **President (Dr. C. Milliken Smith),** commenting upon the paper which had been given, said that one factor which struck him was that when assessing the need for any particular group of officers, it was always the people who were financially concerned who stated the number required, *i.e.*, in the case of speech therapists, educational psychologists, etc., this was assessed according to their own Associations. He had always felt the need for some independent body to decide the number of workers available from a central pool, which would avoid the situation visualised by Dr. Elliott.

**Dr. G. Ramage** congratulated Dr. Elliott on his excellent paper. With regard to one point, he thought that if the rate of production in industry could be increased, more people would be available to man the social services. On the point of shortage of nurses, a statement had recently been made in the Birmingham Hospital Region that the rate of recruitment was satisfactory. It was the rate of loss of nurses which was causing trouble. A striking feature was that the mental institutions had a higher rate of recruitment.

**Dr. A. A. Lisney** thought that members themselves could do something to help in the direction of manpower. The introduction of Hollerith machines by the Dorset county council had helped considerably to reduce the staff engaged on statistical work. With regard to the "middle" section of the population whose work supported the two extremes, was it not a fallacious argument to say that that section was diminishing, and therefore the problem was becoming more serious ? Were there not such things as labour-saving devices which would make an increasing saving in manpower ? There was an indication that at some time in the future our power stations would be driven atomically and we might be able to avoid having to dig for coal.

**Dr. E. C. Huddy** was glad that reference had been made to labour-saving devices. He considered the diagram showing the proportion of the population engaged in agriculture was incomplete, because our country was the most mechanised in the world. Dr. Elliott had referred to life as a "fight"—he thought that we should rather try to adapt and co-operate. He would not consider that food, warmth and clothing were the only basic needs of a civilisation. He thought it a mistake to make the supply of penicillin, insulin, etc., dependent on a charge. A diabetic should not have to pay to keep alive. The present difficulties of the Health Service were due to nothing more than the process of adaptation of resources to means. We, of all people, should be able to envisage the effects of prevention. Surely we could see that in the next hundred years the incidence of disease should be reduced—if not, the Health Services were already redundant. In his view, in 10 to 15 years' time, tuberculosis would be a very different problem from what it was now.

**Dr. W. E. Thomas** said that Dr. Lisney had referred to the need to review establishments. While Dr. Elliott took a much broader view, we must look at the problem from the point of view of our own departments. There seemed to be too much use of female labour in a clerical capacity in the hospitals and he thought this aspect needed rather critical review. On the question of his own nursing establishments, he was often faced with demands for increased staff, particularly for home nursing work, and he always satisfied himself that these increases were really essential. The midwifery service was continually under review.

**Dr. J. A. Fraser** said that Dr. Elliott had given a masterly summary of the situation. He reminded members that Beveridge had envisaged an hotel charge for people going into hospital. He had recently been dealing with two aspects of the Health Service problem. In the first place he had been able to persuade the North Riding Executive Council to ask the Ministry to replace the costly supplementary Eye Service with a Hospital Service ; the replacement of glasses was particularly expensive for Education Authorities when a dispensing fee had to be paid for each repair. He had also suggested that in place of the 1s. charge per prescription, only "official" preparations should be ordered on Forms E.C.10. This would cut out proprietary preparations but allow the life-saving drugs to be prescribed without cost to the patient. On the question of economy in staff, he mentioned the excessive cost of the Children's Department. In his Riding they had had, before 1948, a carefully-worked-out scheme, under which every child was regularly visited at very little cost by health visitors and education staff, but now there was in being a separate service which cost nearly £10,000 a year for visits of inspection alone.

**Dr. J. L. Dunlop** thought Dr. Elliott's views could usefully be conveyed to the C.C.A. and similar bodies, because he saw no prospect of officers trying to limit social services to the bare essentials so long as committees continued to be impressed by the man who did things in the "grand manner" and so long as committees gave little credit to the officer who, by thought and careful planning, was able to maintain an adequate service without frills and at a modest cost.

**Dr. T. Ruddock-West** supported Dr. Fraser on the question of Children's Committees. The Children's Department was one that could be run by the local health authority with greater benefit and less cost to the community. The same remarks applied to all welfare work and probably the institutions as well.

**Dr. G. W. H. Townsend** thought it was easy to criticise others but here we should be critical of ourselves and ask what contribution we could make towards providing the best possible service. There were fields of social work in which some thought should be exercised. For instance, it was more important to have T.B. workers than school visitors. In view of shortages of staff, it was necessary to plan carefully how to use the workers to the best possible advantage.

**Dr. G. F. Bramley** refused to be depressed by Dr. Elliott's remark that we were becoming an older nation and invalidism would increase. If our health services were any good at all the future man of 60 would be a better man than his grandfather was. Serious diseases like cholera and typhoid were conquered in the 19th century without the knowledge of preventive medicine we possessed to-day, and this preventive work must go on.

**Dr. G. E. Godber** agreed that the work of prevention was not finished yet. He asked members to consider what the cost of the Health Service might have been if diphtheria prevention had not been discovered. He thought we were just on the point of being able to conquer tuberculosis. The number of deaths this year was likely to fall below 10,000 and the number from the great towns was under 100 weekly for the first time. Although the incidence, as shown by notification, only gave a slight fall, it was not known how far these figures mirrored the true situation. It was known that waiting lists were going down and he believed that in five years' time we should be facing an actual drop in tuberculosis cases. In ten years' time we could have tuberculosis completely under control and that would mean that the greater part of 26,000 beds would be released together with great numbers of doctors and nurses.

Dr. Godber pointed out that the curative services could not be separated from the preventive services and he thought the curative services needed some impartial critic at their elbow to see that they were properly used along with the preventive services.

The Hospital Service could be improved a great deal—it could be made much more efficient and consume considerably less manpower. There were striking degrees of variation in the use of hospital beds by different hospitals—in one, for instance, the number of patients going through a bed in one year was 29, while in another case it was only eight. Furthermore, no self-respecting American hospital would own to an average stay by a patient of more than 10 to 11 days, but very few English hospitals could claim such a short stay, and at least three teaching hospitals in London had an average of 20 days. That was where resources were being wasted and he was sure the hospitals could be managed with fewer beds and fewer personnel.

Efforts were also being wasted in trying to operate old and inefficiently equipped hospitals. It was not merely inconvenient but also uneconomical to carry patients up and down stairs when a lift could be put in. One of the larger teaching hospitals had only two lifts and apparatus had to be duplicated on one or two floors because patients could not be easily moved up or down. He was sure running costs could be cut by a little capital expenditure now. He thought the next 10 years must be devoted to trying to make the Health Service work more efficiently.

Dr. Godber sympathised with the cry for fewer statistics, but could he counter with a request for more accurate ones? It was purposeless to collect for central use compendia of figures to put before officials just to save them the trouble of reading the report of the Medical Officer of Health. In return for agreeing to ask for fewer statistics, he would ask to have reports sent in earlier. On the question of life-saving drugs Dr. Godber said that several countries had official lists of drugs, but there were obvious dangers in this method. Australia and Denmark were two of these countries, but they found it necessary to review the list frequently. It was very difficult to keep it stable, as many different things could be described as "life-saving." The Australian list included a large number of proprietary drugs. The Ministry had considered the idea very carefully but thought it would do more damage than it was worth. The cost incurred by the diabetic for insulin was not very great, and if he was destitute there were means to help him.

**Dr. Lisney** said he thought it seemed logical that the welfare services, including Part III accommodation, should be run by the health department, thus saving manpower. Also, as an example, the situation arose where lay staff dealing with the admission of cases to Part III accommodation were not in a position to discuss the case with a general practitioner recommending admission if this appeared unsuitable on medical grounds. In a recent circular from the Ministry on handicapped persons, which was fundamentally a medical problem, it was stated that a sufficient number of welfare officers would be approved. As he had pointed out to his committee, the health visitor could do this work without them appointing further specialised staff.

**Dr. Elliott,** replying to some of the points raised, said that in his opinion the situation could not be met by unilateral action by local authorities and, even if they took part in some wider measure of planning, the answer, so far as they were concerned, did not lie in the absorption of other departments. The President had made the position clear, there needed to be some authority that could lay down the proportion of man and womanpower that the social services could utilise and each social service ought then to consider how best to employ the share that it could have now and in the future. The average age of the population was rising and with the increasing number of older people invalidism was bound to increase. Anyone who studied the absorption of resources and manpower in the geriatric units could anticipate the demands that must inevitably arise in the next few years and could reflect on the figures given in his address. The number of women available for work was going to decline because of the low birth-rate in the past.

As to the points made about economies in the hospital services he was sceptical as to their value. He foresaw that the rate of saving in resources and womanpower, in, for example, the field of tuberculosis, would be slower than the demand for utilising such facilities in other expanding parts of the hospital services. It seemed to him that there had to be a wider realisation of the peril in which we stood and hence the limitation in the amount of manpower that the social services could have from the national pool. He said that it had never been possible to put the clock back and specialisation was here to stay, since modern civilisation could only be carried on by an extreme subdivision of specialised labour. He was not so optimistic as to suppose that our particular form of civilised organisation could last for ever, but he did think that the decline need not be so rapid. Past civilisations had been overthrown through the neglect of one or more of the basic criteria he had described, usually an undue preoccupation with the raising of internal standards of living at the expense of protection against external enemies. It seemed that at present we were living under conditions parallel to those of a siege war, but the vital factors governing production, manpower and resources were not organised to meet these conditions.

In conclusion, the President remarked that the Association did not often have the opportunity of listening to papers which were characterised by a broad philosophical basis, but he was sure that members were really grateful to Dr. Elliott for his address. His paper was the result of a critical study of the situation. Dr. Elliott was a realist and it was realism that was required to tackle the problems of the Health Service as it existed to-day. He thanked Dr. Elliott very warmly.

## CORRESPONDENCE

CIRCULAR 28/52

*To the Editor of* PUBLIC HEALTH

SIR,—Dr. Belam and Dr. Booth, writing in your November issue, appear to assume that all passengers arriving on an aircraft are necessarily to be dealt with as contacts if one of them later becomes ill. If infectious disease occurs on an aircraft, the passengers should be dealt with as contacts by the airport health control. If, as has usually been the case, the disease develops after arrival in this country, it is unlikely that the other passengers will be contacts. If they should be, they will probably be better protected against smallpox than most of our population. There is no record of major infectious disease occurring among aircraft passengers in this country as a result of a case occurring in one of their number.

I have on many occasions while working in an airport health control doubted the value of obtaining the address to which passengers proceed. Also many give accommodation addresses and many of these fail to return the reply cards issued. A traveller who would ignore a B.B.C. or Press notice would hardly bother to return a reply card.

Experience has shown that air travel may introduce smallpox. Abolition of the personal declaration should have little effect on the degree of risk involved, which can only be completely abolished by strict quarantine, a procedure difficult to justify. As long as smallpox is endemic in some countries, the greatest weakness seems to be the small proportion of people vaccinated in this country. This may be altered by panic such as that to which Dr. Booth refers, but there was little sign of this when B.B.C. and Press notices were recently put out in accordance with Circular 28/52.

Health Department,
Civic Centre,
Southampton.
*November 29th*, 1952.

Yours faithfully,
W. P. CARGILL,
*Deputy Medical Officer of Health.*

## INTERNATIONAL CONGRESS OF HYGIENE AND SCHOOL MEDICINE, LYONS, 1952

Dr. J. E. Cheesman, as delegate from the School Health Service Group of the Society and *membre Correspondant étranger de la Societé francaise d'Hygiène Scolaire*, attended the above Congress held on July 9th, 10th, 11th and 12th last, and has sent the following account of the proceedings :—

This was the second congress organised by the International Society of School and University Hygiene, with the co-operation of the local Medical Faculty. The first was held in Paris in 1947, and the delegates who attended from Great Britain were a representative from the Special Services Branch of the Ministry of Education and two members of the School Health Service Group. These congresses are now established quinquennial events. Lyons, a city of 440,000 population, is some 440 miles distant from the ferry at Dunkerque, by a first-class road running through many front-line towns of the first World War. Well laid out on the banks of its two rivers, it is a handsome modern town, but of sufficient antiquity for planning and replanning to have taken place ; consequently, the new building for the Medical Faculty, separated from the older University buildings on the South Bank of the Rhône, is sited, together with the main hospital, the distance of a sixpenny tram-ride from the Place Bellecour, the shopping and business centre of Lyons. The Faculty building had the usual medical school accommodation with lecture theatres of ample proportions where the papers and reports were read. Some 300 delegates attended from 14 different nationalities.

The congress was arranged according to the usual convention, as follows : (A) Opening and closing ceremonies, an official reception at the Town Hall, a ceremonial dinner and lunch. (B) Original papers read with and without the aid of the cinema. (C) Visits to institutions of interest to *Medicine Scolaire*, which is fully recognised on the Continent as one of the most promising fields of preventive medicine of the future.

(A) The various ceremonies played their part in knitting into a whole and keeping together what began by being an assembly of shy and polyglot strangers. As one of our considerate hosts put it, " Much of the value of congresses lies in the bringing together of enthusiasts as well as experts, and affording facilities for them to get together and exchange ideas outside the actual lecture hall."

Besides representatives of the international body and local medical faculty, the Minister of National Education attended in person, as well as the recently appointed civil administrator of the School and University Health Service. M. Herriot, the Mayor of Lyons, an historic personality, was unfortunately prevented from presiding over the civic ceremony.

### Papers and Discussions

(B) The papers and reports of school health service work were read in French by delegates from many areas in France, as well as from London, Stockholm and Genoa. They were confined to communications under three groups as follow :

(1) *Tuberculosis in Schools.—E.g.*, discovery and prevention. New technique in skin reaction. Radiology. Bovine tuberculosis. Gaps in the protection of children from contagious staff. Sources of infection in teachers' colleges, etc.

(2) *Mental, Sensorial, Physical, and Character Handicap.*—The adolescent. Deficiency of intellect in the rural area. Warning symptoms or neuropsychosis in the school entrant. Intellectual retardation with character abnormality. Differential diagnosis E.S.N. and infantile schizophrenia. Vocational education by raising school-leaving age. Reading difficulties. Ascertainment of tonal deafness. Teaching of physically handicapped and recumbent children. Classes for the maladjusted in secondary schools, etc.

(3) *Miscellaneous Subjects.*—Rôle and function of school hygiene. Organisation of school and university health service. Modification of school holidays in senior schools and colleges. Canteens and distribution of ancillary nourishment in the town of Lyons. Systematic research on threadworms in Lyons. Prevention of ringworm by preliminary U.V.R. investigation. Centres of endemic goitre in the Loire district. Obesity in childhood. Detection of colour blindness. Lighting of class-rooms. Dental control in primary schools. Role of dental auxiliaries as envisaged in France. Benefit of open-air schools. Combined physical education and heliotherapy at school. Sun cure at holiday camps. Biometric survey and comparison of metropolitan and North African children. Surveillance of the apprentice. Treatment of scoliosis (film). Future of the bronchiectatic. Social incidence of chronic suppuration in the respiratory passages (film made at Dieulefit).

### Visits to Handicapped Children's Colonies

(C) Besides a visit to the local dispensary these were made in the course of an excursion, which lasted the whole day, because of the long distances involved, to two of the open-air child village colonies, or " *aeria*," which are administered from Lyons. The whole undertaking, which is registered under the title of " *Oeuvre des Villages d'Enfants*," comprises nine establishments situated in the Departments of Haute Savoie, Isère, Drôme, Loire and Rhône. They cover the functions of schools for delicate, debilitated, rheumatic and pre-tubercular children (*aeria*), E.S.N. children (*medico-paedagogiques specialisés*) and maladjusted children (*maisons à caractère sanitaire*), although the latter are also the special responsibility of the associated societies for child protection. Children recommended are those whose state of health justifies separation from the family circle and placing under good physical and normal conditions. The family atmosphere is maintained by boarding in houses with small staff. The teaching administration depends on public school teachers and the medical on a doctor assisted by State registered nurses. New methods of teaching are employed which not only avoid untimely fatigue for the child, but, by aiding his psychological and moral development, contribute to the salutary effects of the cure. The educational standard permits children to sit for the higher examinations. All establishments are " recognised " by the social security, free medical societies, etc. Cases of tertiary and recent primary tuberculosis are not admitted.

*Dieulefit* (Drôme), altitude 400 m. ; semi-Provencal climate ; takes chronic asthmatics, slight bronchial dilatation, congenital and rheumatic hearts, recurrent bronchitis. Lipiodol and bronchoscopies are undertaken and it has more the character of a clinic than a rest-house.

*Roybon* (Isère) takes cases of subnormal nutrition and contacts, with negative skin reactions in preparation for B.C.G. vaccination after verification of desensitisation, and until immunity is established.

### Conclusion

An impression remains of a well-organised and well-documented school health service, more scattered than in the United Kingdom, but for that reason more locally self-reliant and independent. British contributions included a paper on physical handicap, read in French by an L.C.C. teacher, and a copy of the late Dr. E. H. Wilkins's " The Medical Inspection of Schoolchildren," which was displayed at the enquiry office of the congress, and on sale in Place Bellecour. Some 200 leaflets were taken away by delegates. Representative papers, including " The Health of the School Child," and reports from members of the Council of the School Health Service Group, and four film strips, were exchanged with similar publications already in print from French sources. As on the previous occasion, a copy of all the papers read at the congress will be published in book form and will be available as soon as printed, about February, 1953. Important contacts were made between French and British health services and a liaison re-established.

## OBITUARY

CHARLES PORTER, M.D., C.M., B.SC. (P.H.), EDIN., M.R.C.P. (EDIN.), Barrister-at-Law

The Society has to mourn the death on December 15th, at the age of 79, of one of its senior Past-Presidents, Dr. Charles Porter, for 29 years Medical Officer of Health for St. Marylebone Metropolitan Borough.

Dr. Porter graduated at Edinburgh in 1898, took his B.Sc. in public health in 1900 and proceeded M.D. in 1902. After a period at Freiburg University and various hospital appointments, he became an Assistant Medical Officer in Sheffield and later in Leeds, whence he was appointed M.O.H. for Finsbury Metropolitan Borough. In 1910 he was appointed to St. Marylebone, where he remained until his retirement in 1939, though, as mentioned below, he served three other London boroughs during and after the war. Throughout his career he was engaged for part of his time in teaching public health and he was lecturer on this subject at the Middlesex Hospital medical college for most of his period in St. Marylebone. His first well-known book, "Sanitary Law and Practice," was written in collaboration with Dr. W. Robertson, of Edinburgh. His later book dealing with public health law in question and answer, with Dr. James Fenton as co-author, and in its most recent edition with Dr. J. Greenwood Wilson as editor, has also served several generations of public health students and medical officers.

Dr. Porter took a very active part in this Society and in the Royal Sanitary Institute, having been President of the former for 1933-34 and chairman of council, R.S.I., from 1931 to 1933. But here he will be best remembered as a formidable debater for many years in the Council and as the honorary editor of this journal for 10 years from 1925. As an editor, he showed his individuality by his comments, always recognisable by their style, and short introductions to special articles. Although he dropped out of the Society's Council before his retirement from St. Marylebone, he kept up his active association with the R.S.I. to the end. His experience in public health matters was in much demand by Governmental and other bodies on many of which he served, including the General Nursing Council and the Queen's Institute.

After his official retirement in 1939, he was brought back into harness as acting M.O.H. of Greenwich for the duration of the war. Then in 1946 he became temporary M.O.H. Paddington, and finally he served a year from August, 1948, to July, 1949, in Bethnal Green. By that time his health was deteriorating and for three winters he sought the sun overseas in Egypt and South Africa, but, owing to his election in 1952 as Master of the Worshipful Company of Plumbers, he decided to stay in England during his period of office. Members will recall that he and Mrs. Porter attended the Annual Dinner of the Society in October last. The early wintry weather, however culminating in the great London fog last month, was a great strain and he passed away in the Middlesex Hospital after a short illness.

The Society's sympathies are extended to Mrs. Porter and to his children by his first wife—a son, who is in general practice, and three daughters.

DUNSTAN BREWER, M.R.C.S., L.R.C.P., D.P.H.

We regret to record the death on November 30th, in his 78th year, of Dr. Dunstan Brewer, for many years Medical Officer of Health and School Medical Officer for the Borough of Swindon. Brewer was born in London, a son of an architect and a great-nephew of the Brewer of the "Dictionary of Phrase and Fable." He graduated from St. Mary's and University College in 1897 and took the D.P.H. in 1904. After spells as house officer in the M.A.B. hospitals, S.M.O. in the West Riding and M.O.H. of East Gloucestershire sanitary districts he was appointed M.O.H. and S.M.O. of Swindon, where he spent the rest of his career till his retirement in 1939. Brewer's appearance and manner of speaking will be well remembered by those who recall his interventions in health congress discussions. It is perhaps not generally known that for nearly 30 years he was a regular contributor to the editorial columns in our contemporary *The Medical Officer*, where his original statements have caused general interest. His contributions emanated from a mind with a catholic range of interests and a highly enquiring disposition combined with a keen sense of observation. He personally supervised the keeping of the records of children's health during his long period in Swindon and with this intimate knowledge of the medical histories he could apply his personal source of information when new theories of health and disease were under discussion. He was also the medical superintendent of the Borough Isolation Hospital and there again kept personal contact with infectious diseases in their changing manifestations. He was pre-deceased by his wife but during his last years found a happy home with his daughter and clerical son-in-law in the Midlands.

SIR DAVID MUNRO, K.C.B., C.I.E., LL.D., M.B., F.R.C.S. (EDIN.)

Sir David Munro, whose death in his 75th year occurred on November 8th, was for many years a member of the Society, which he joined as an early member of the Services Group in 1921 when he held the rank of Air-Commodore. He was born in Hertfordshire in 1878 and joined St. Andrews University at the age of 14, remaining there for six years; thence he graduated in medicine at Edinburgh University in 1901 and joined the Indian Medical Service. He served in a hospital ship and in France, Palestine and Mesopotamia in the first world war and was created C.I.E. in 1917. He transferred to the R.A.F. in 1919 and in 1921 was appointed Director of R.A.F. Medical Services, a post which he held till 1930. He was created C.B. in 1924, K.C.B. in 1930 and was Honorary Surgeon to the King from 1925 to 1930. On retirement from the R.A.F. in 1930 he was appointed by the M.R.C. as Secretary of the Industrial Health Research Board and he gave valuable administrative service there until 1942. Meantime he had been appointed Chief Medical Officer of the Ministry of Supply where he supervised the health of workers in the Royal Ordnance factories. One of his final posts came with his election by the students to be Rector of St. Andrews University, which office he held from 1939 to 1946. Amongst his other interests was the London School of Hygiene and Tropical Medicine, for which he was vice-chairman of the Board of Management. The story of Munro's career will give some idea of the multiplicity of his interests and he will be remembered by many members of the Society as a man of forceful and pleasant personality with a great fund of experience. He is survived by his widow, a son, a daughter and grandchildren, to whom we express our sympathy.

JOHN WILLIAM TALENT, M.D., C.M. (EDIN.), M.R.C.S., D.P.H.

We regret to record the death at Grange-over-Sands on October 17th last, in his 89th year, of Dr. J. W. Talent, who was Medical Officer of Health for the Borough of Ashton-under-Lyne from 1909 until 1935. Dr. Talent graduated in medicine at Edinburgh University in 1886 when he was awarded the Buchanan Scholarship. After a short period as a ship's surgeon he took up private practice in Ashton, then in 1909 he took the D.P.H., Manchester, and was appointed M.O.H. for the Borough. He was M.O.H. during all the formative years of the public health services and played a conspicuous part in the affairs of the North-Western Branch, of which he was at one time President, and in all the life of the town. During his years of retirement he was able to enjoy his hobbies of botany and music. He was elected a fully paid Life Member of the Society when he gave up his post. He is survived by his widow, a son and a daughter, to all of whom we express our sympathy in their loss.

## BOOK REVIEWS

**Porter and Fenton's Public Health Law in Question and Answer.** 5th Ed. By J. GREENWOOD WILSON, M.D., F.R.C.P., D.P.H., assisted by J. HINDLE FISHER, LL.B., D.P.A. (Pp. 342. Price 27s. 6d.). London: H. K. Lewis & Co.

There appeared 42 years ago, when Public Health Law was mainly Sanitary Law, the first edition of Porter and Fenton's "Sanitary Law in Question and Answer," a book that became well known and well used in public health circles. By 1939 it had passed through four editions and now, after the passage of another 13 years, a new and much enlarged edition carrying the title "Public Health Law in Question and Answer" has been published—on this occasion under the authorship of Dr. J. Greenwood Wilson, who as a Medical Officer of Health is as prominent in his generation as Charles Porter and James Fenton were in theirs. In the task of compiling the new edition, Dr. Wilson has had the assistance of a solicitor colleague, Mr. J. Hindle Fisher, whose name is linked with the author's on the title page.

The question and answer method of presentation, eminently suited to instruction by word of mouth, has serious limitations in print in many medical fields, but with Public Health Law the position is rather different. The great consolidating Acts of the thirties and since have eased the Public Health student's task in some respects, but against this the enormous expansion of new law which medical students, medical practitioners and social workers need at least to be familiar with has added greatly to their burden of reading. So great, indeed, is the volume of recent legislation that graduates specialising in Public Health are hard pressed to keep pace with it and are grateful to anyone who undertakes the arduous and rather thankless task of compiling a reliable

précis of essential provisions. Dr. Greenwood Wilson and his collaborator have done this in the present work with great competence. They have used the question and answer method of presentation as a scaffolding for an orderly exposition of Public Health Law as it now exists, and their treatment is sufficiently complete to serve two somewhat different purposes. It is enough without further elaboration for the general student; and secondly, it provides a valuable starting point for the specialist who requires to find his way through statutes and statutory instruments in the original over a wide range of medical, sanitary and social subjects.

The book is arranged in seven parts. Part I comprises Public Health Administration and the Public Health Act, 1936; Part II, Communicable Diseases; Part III, Social Security Legislation; Part IV, Housing and Town and Country Planning; Part V, Food and Drugs; Part VI, Factories; Part VII, a Miscellany of relatively circumscribed subjects such for example as Pharmacy and Poisons, Shops, Children, and Midwives. There is a comprehensive Table of Statutes and an adequate Index.

Primarily the volume is a work of first reference and used as such it should prove valuable on the desk of medical officers of health and many other officers in the Local Government Service. Dr. Wilson has, however, succeeded in bringing readability to terms with summary statement, to the extent that this can be expected of epitomised Public Health Law. The book should be virtually self-sufficient for health visitors, almoners and other social workers and almost so for the student Sanitary Inspector.

The authors have, of course, found it impossible to include everything that might have been included, but to say this is not an adverse criticism. Two deliberate limitations should be mentioned. First, only the Public Health Law of England and Wales is given (i.e., references to special provisions in London and elsewhere are expressly omitted), and secondly, a final date was very wisely fixed after which more recent legislation is excluded. The date chosen for this purpose is January 1st, 1952.

The author and his collaborator are to be congratulated on a toilsome job done with accuracy and discretion, and the publishers on a legible, convenient and tastefully produced volume.

**Non-Pulmonary Tuberculosis of Bovine Origin in Great Britain.** By G. S. WILSON, M.D., F.R.C.P., D.P.H., J. W. S. BLACKLOCK, M.D., F.R.F.P.S., and L. V. REILLY, B.SC., M.D., D.P.H. (Pp. 108; maps and diagrams. Price 16s.) London: National Association for the Prevention of Tuberculosis, 1952.

This volume comprises a collection of reports on the above subject in England, Wales, Scotland and Northern Ireland, with a general commentary. The Scottish report is published for the first time, the others are reprinted from *The Journal of Hygiene*, by permission of the Editor and the Syndics of the Cambridge University Press. It is estimated that "in Great Britain as a whole in 1944 about 550 deaths from tuberculous meningitis and about 1,050 from other forms of non-pulmonary tuberculosis were due to infection with the bovine type of tubercle bacillus. In Scotland alone between 3,000 and 4,000 of the notified cases of surgical tuberculosis were due to the same type of bacillus. For this imposing total of unnecessary and readily preventable disease, the blame must be laid almost wholly on raw infected milk."

Perusal of this useful compendium of the evidence will make the public health officer hope that the Minister of Agriculture will extend the areas of compulsory pasteurisation more rapidly than has been the case hitherto. The case for universal pasteurisation seems to have been established in all quarters but not the sense of urgency which we attach to it.

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The National Society of Children's Nurseries is organising a one-day conference on "Human Relationships and the Young Child," to be held on Friday, February 13th, 1953, at 10.30 a.m., in the Barnes Hall of The Royal Society of Medicine, 1, Wimpole Street, London, W.1, with Dr. J. A. Scott, O.B.E., M.O.H., L.C.C., in the chair. At the morning session, to be opened by Major Cyril Nathan, F.C.A., Chairman of the National Society, the speakers will be Dr. Neil R. Beattie, Ministry of Health, and S. Yudkin, chief paediatrician, Whittington Hospital. In the afternoon the opening speaker will be Dr. Doris Odlum, President, Medical Women's Federation, Vice-President, National Association for Mental Health. The conference fee is 10s. Applications should be made to The Secretary, National Society of Children's Nurseries, 45, Russell Square, London, W.C.1.

## SOCIETY OF MEDICAL OFFICERS OF HEALTH

### Ordinary Meeting, September

An Ordinary Meeting of the Society was held in the Lecture Theatre, London School of Hygiene and Tropical Medicine, on Thursday, September 18th, 1952, at 5.30 p.m. The chair was taken by the retiring President (Dr. W. G. Clark) and there were also present approximately 130 members.

*Minutes.*—The minutes of the meeting held on July 19th, 1952, were confirmed and signed.

*Installation of President.*—Dr. W. G. Clark said that it gave him great pleasure to install as his successor in the presidential chair Dr. Andrew Topping, Dean of the London School of Hygiene and Tropical Medicine. He invested Dr. Topping with the badge of office and the latter briefly thanked the Society for the honour which had been bestowed upon him. A hearty vote of thanks to the retiring President was proposed and seconded and carried with acclamation. Dr. Clark thanked the members of the Society and the staff for the support which had been given him during his year of office.

*Election.*—The following candidates having been duly proposed and seconded were then elected to membership:

*Fellows.*—Crowdy, Joseph Porter, M.B., CH.B. (EDIN.); Houston, Roy Robertson, M.B., CH.B. (GLAS.), D.P.H.; Kelynack, Agnes Violet, M.D., B.S. (LOND.), M.R.C.S., L.R.C.P.; Martin, Randall, M.B., CH.B., D.P.H.; Peet, Elsie Lilian, M.D. (DURH.), B.S., L.D.S.; Randall, Gladys, M.B. (LOND.), D.P.H.; Stewart, Audrey Elizabeth, M.B., CH.B. (GLAS.), D.R.C.O.G.;

*Associates.*—McCarthy, William, L.D.S. (BELF.); Parsons, Douglas Mervyn, L.D.S. (BIRM.).

Dr. Topping then proceeded to give his Presidential Address entitled "Prevention—Medical and Economic" (published in PUBLIC HEALTH, November, 1952). A vote of thanks for the address was proposed, seconded and carried unanimously.

The meeting then terminated.

### Ordinary Meeting, October

An Ordinary Meeting of the Society was held in the Council Chamber, B.M.A. House, Tavistock Square, London, W.C.1, on Friday, October 24th, 1952, at 12.45 p.m. The President (Dr. Andrew Topping) was in the chair and there were also present approximately 30 members.

*Minutes.*—The minutes of the meeting held on September 18th, 1952, were confirmed and signed by the Chairman.

*Transfer to Fellowship.*—The transfer of Mr. S. B. Newton, L.D.S., from the Associate membership to the Fellowship of the Society was recorded.

*Election.*—The following candidates having been duly proposed and seconded were then elected to membership:

*Fellows.*—Bobbett, Patrick Mary Joseph, M.B., B.CH., B.A.O. (DUB.), D.P.H.; Brodbin, Patrick, LL.M., L.R.C.P.L.S.I. (IRE.); Bryant, Hugh O. M., M.B., CH.B. (LIV.), D.P.H.; Cassells, Nulece, M.B., CH.B. (GLAS.), C.P.H.; Davies, David Joseph, M.B.E., B.S., M.D. (CARD.), D.P.H.; Garry, Michael Gerald, L.R.C.S.I., L.R.C.P.I. & L.M.; Habgood, George, M.B., B.CH. (CANTAB.), D.P.H.; Hall, Harry Donald, L.D.S. (ENG.); Hooper, Francis John Winsmore, M.B., CH.B. (BRIS.), D.P.H.; Kelly, John, M.B., B.CH., B.A.O.; MacKinnon, Marion S., L.D.S. (GLAS.); Morgan, John Gwynne, C.B.E., M.B., B.S. (LOND.), D.P.H., T.D.; Ridehalgh, Nora, M.B., CH.B. (VICT.); Sandford, Irene Emily, M.R.C.S. (ENG.), L.R.C.P., D.P.H.; Shaw, Joyce, M.B., B.S. (DURH.); Skone, John Francis, M.D., B.S., D.P.H., D.C.H., D.I.H.; Tracey, Vivien, M.B., B.CH. (WALES), D.C.H.; Turner, Agnes Frances, M.B., CH.B. (EDIN.), D.P.H.; Williams, Frances Anne, M.B., B.D. (LOND.), M.R.C.S., L.R.C.P., D.P.H.; Willison, Jean Campbell, M.B., CH.B. (EDIN.), D.P.H., D.C.H.; Davies, Rowland Gwyn, M.D. (LOND.), D.P.H.

Several nominations for the next election were reported. The meeting then terminated.

### Annual General Meeting

The Annual General Meeting of the Society was held in the Committee Room of the Society, Tavistock House South, Tavistock Square, London, W.C.1, on Thursday, December 11th, 1952, at 5.30 p.m. In the unavoidable absence of the President through illness, the chair was taken by the Senior Vice-President (Dr. W. G. Clark) and there were also present 12 members.

*Minutes.*—The minutes of the Annual General Meeting held on December 21st, 1951, were confirmed and signed by the Chairman.

*Annual Reports and Accounts.*—The annual reports of the Council, of the Hon. Treasurer and of the Editor of PUBLIC HEALTH for the session 1951-52 were received and adopted, together with the balance sheet as at September 30th, 1952, and the income and expenditure account for the year ended September 30th, 1952. On the proposition of Dr. H. Kenneth Cowan, and seconded by Dr. C. Herington, it was resolved "That this meeting is of the opinion that the size of the Council of the Society is too large in proportion to the total membership and that steps be taken to amend its constitution in order to reduce its size. It requests, therefore, the Council of the Society to discuss the ways and means by which this decision can be implemented."

*Appointment of Auditors.*—It was resolved to authorise the Council to appoint the auditors for the session 1952-53.

*Election.*—The following candidates, having been duly proposed and seconded, were then elected to membership:

*Fellows.*—Andress, John, M.B., B.CH., B.A.O. (BELF.), D.P.H. ; Bennett, Thomas Ronald, M.R.C.S., L.R.C.P. (LOND.), D.P.H. ; Brodie, James Hurrie, M.B., CH.B. ; Castles, Wilfred, M.B., B.CH. (BELF.), D.P.H., M.R.C.V.S., D.V.S.M. ; Crawford, Leonora A., M.B., B.S. (LOND.), D.P.H., D.C.H. ; Davidson, Sheila P., M.B. (GLAS.), D.R.C.O.G. ; Elliott, Evelyn Sarah, M.B., B.S. (LOND.), L.R.C.P., M.R.C.S. ; Fyfe, George, M.B., CH.B. (ST. AND.), D.P.H. ; Fyfe, Isobel M., M.B., CH.B., D.P.H. ; Gemmill, James S., M.B., CH.B. (GLAS.), D.P.H., D.P.A. ; Goose, Denys Halley, B.SC., B.D.S., L.R.S., R.C.S. (ENG.) ; Griffith, Arlwyn Hughes, M.B., B.S. (LOND.), D.P.H. ; Griffith, Patrick G. H., L.D.S. (BELF.) ; Hall, William, M.B. (MANCH.), M.R.C.S., D.OBST.R.C.O.G., D.P.N. ; Howarth, Bessie, M.B., CH.B. ; Kennedy, Alan Robert, M.B., CH.B., M.R.C.S., L.R.C.P. (LOND.), D.P.H., B.SC. ; Keys, David Noble, M.B., B.S. (DURH.), D.P.H. ; Leach, Irene Mary, M.B., CH.B. (MANCH.), M.R.C.S., L.R.C.P., D.C.H. ; Lucey, John Francis, M.B., B.CH., D.P.H. ; McGrath, M.B., B.CH. (BELF.), D.P.H. ; Maclean, Christina Isabella, M.B., CH.B. (GLAS.) ; MacTaggart, Douglas Keith, M.A., M.B., CH.B., D.P.H. ; MacTaggart, June Mary, M.B., CH.B. (ABERD.), D.P.H. ; Marshall, Annabella, M.B., CH.B. (GLAS.) ; Pinkerton, Isabella Madeleine, M.B., B.CH. (WALES), D.P.H. ; Pinkerton, Norah D., B.SC., M.B., B.S. (LOND.) ; Reid, John James Andrew, B.SC., M.B., CH.B., D.P.H. (ST. AND.) ; Sheane, Eric L., L.D.S. ; Shearer, Charles William, M.B., CH.B. (EDIN.), D.P.H. ; Smith, Geoffrey Robson, L.D.S., R.C.S. (EDIN.) ; Stride, William H. B., L.D.S., R.C.S. (ENG.) ; Thomson, Donald Glen, T.D., L.D.S., R.C.S. (ENG.) ; Warren, Michael Donald, M.D., D.P.H., D.I.H. ; Williams, Ursula Elizabeth, M.D. (BERNE), D.R.C.O.G.

*Associate.*—McGonigal, Francis, L.D.S., R.F.P.S. (GLASG.).

Names of candidates for the next ensuing election were reported. There being no other business the meeting terminated at 6.15 p.m.

## GENERAL PURPOSES COMMITTEE*

A meeting of the General Purposes Committee of the Society was held in the Committee Room of the Society, Tavistock House South, Tavistock Square, London, W.C.1, on Friday, September 19th, 1952, at 10 a.m.

**Present.**—The President (Dr. W. G. Clark), Drs. J. M. Gibson, H. D. Chalke, F. M. Day, James Fenton, Miriam Florentin, Maurice Mitman, A. A. E. Newth, Mr. A. Gordon Taylor, L.D.S., Dr. W. S. Walton. (Also present : Drs. F. G. Brown, George Buchan, J. S. G. Burnett, T. M. Clayton, Kathleen M. Hart, R. H. H. Jolly, J. B. S. Morgan, Hugh Paul, Nora Wattie, H. C. Maurice Williams and A. V. Kelynack.)

**Appointment of Chairman.**—In the absence of Dr. H. Kenneth Cowan, who was unavoidably prevented from attending the meeting, it was resolved that Dr. J. M. Gibson take the chair for the meeting.

**Apologies for Absence were received from :** Drs. C. Metcalfe Brown, H. K. Cowan, C. K. Cullen, J. A. Stirling and Andrew Topping.

213. **Minutes.**—The minutes of the meeting of the Committee held on Friday, March 7th, were confirmed and signed by the Chairman.

214. **Whitley Medical Functional Council.**—Dr. A. V. Kelynack, Assistant Secretary of the B.M.A., gave a verbal report on the present position with regard to the implementation of the Awards of the Industrial Court and also on the results of certain appeals which had been heard recently.

215. **Dual Appointments.**—The Committee had before them a copy of a letter from the Minister of Health dated September 15th, setting out the proposals regarding the principles to be followed in calculating the salary of officers who hold appointments both with L.H.A.s and R.H.B.s but who had abstained from signing permanent contracts. It was resolved that the whole matter be left in the hands of the representatives of the B.M.A. for them to make the best arrangements possible. In particular it was felt that this might be achieved by getting the functions of the proposed joint advisory committee widened so far as possible and the Committee supported the suggestion that the professional organisation of the officer concerned should be empowered to apply for an appeal to the advisory committee.

216. **Durham County Council—Closed Shop.**—It was formally reported that the decision of the tribunal in the Durham C.C. Closed Shop dispute was favourable to the Joint Emergency Committee of the Professions. The meeting expressed appreciation of the efforts of those concerned in the handling of the dispute from the Employers' Side.

217. **Public Health (Infectious Diseases) Regulations.**—A memorandum on the notification of infectious diseases prepared by Dr. Hugh Paul was received and the recommendations contained therein considered. It was resolved to *recommend* the Council (1) that the Ministry of Health be approached to make notifiable the following diseases in all areas : Hepatitis, infective or serum ; Glandular fever ; Leptospiral infection, including both Weil's Disease and Canicola Fever ; Brucella infections ; and (2) that the Ministry of Health should be asked to sponsor investigations on the lines adopted in relation to rheumatism which has been made notifiable in Bristol, Sheffield, East Anglia, etc., where the notification is for the specific purpose of research into the epidemiology of the notified condition. The Committee also considered the recommendation of the Sheffield Pre-Liaison Committee that there be no change in the requirement for the notification of puerperal pyrexia. Members were reminded that the Ministry had recently been advised by the Society to continue this requirement and that there was no need therefore to take any action on this recommendation.

218. **Dentists Bill.**—It was reported that the Council of the Dental Officers' Group were not convinced that it was desirable to produce a memorandum on the future of the School Dental Service, especially in view of the recent combined circular issued by the Ministries of Health and Education. It was left to the Dental Officers' Group to produce a memorandum as and when they thought it desirable.

219. **Status of M.O.H.s.**—The President (Dr. W. G. Clark) reported that the Scottish Branch of the Society had investigated the conditions of service attaching to a post of County M.O.H. in Scotland and that it was felt that no further action was necessary.

220. **Employment of Older Men and Women.**—The President reported that it was hoped to have a memorandum on the Employment of Older Men and Women drafted in time for circulation at the next meeting of the Committee.

221. **Membership of Council.**—(*a*) It was reported that the majority of Branches and Groups had agreed in principle to carry out the suggestion of the Council that they voluntarily reduce the number of their representatives on the Council of the Society but had appointed the full number of representatives on the understanding that not all of them would attend the meeting at the same time. On the recommendation of the Hon. Treasurer it was decided that this arrangement be approved and that the Branches and Groups concerned be thanked for their co-operation in this matter.

222. **Decentralisation.**—It was reported that the document adopted as the official policy of the Council had been circulated to the Ministries of Health and education and the Local Authority Associations. No comments had been received to date.

223. **Local Government Act, 1933.**—It was reported that opinions expressed on the draft document suggesting a population figure which needed the appointment of one whole-time M.O.H., in meetings of the County and County District Groups to whom the report had been forwarded for comment, were divided, that the preparation of a further report was extremely difficult. It was resolved to recommend to Council that a sub-committee consisting of the President and two County M.O.s and two County District M.O.s be appointed to consider this matter further.

224. **Institute of Public Administration.**—It was reported that the publication of the Institute of Public Administration "Autonomy and Delegation in County Government" could be obtained from the Central Office at a special reduced price of 4s. 6d. per copy.

225. **Maternal Deaths.**—A letter from Dr. Charles Cookson, Gloucester C.B., drew the attention of the West of England Branch to the inclusion by the Registrar-General amongst maternal deaths in 1950 that of a 63-year-old woman who died from a venous thrombosis and pulmonary embolism after an operation for pelvic repair. Dr. Miriam Florentin stated that the Maternity and Child Welfare Group was also aware of five other similar cases. It was the opinion of the meeting that the inclusion of such deaths amongst the maternal deaths statistics destroyed the value of mortality deaths figures and it was resolved that a letter be addressed to the Registrar-General drawing his attention to this practice. Dr. Cookson had also raised the question of the wording of the C.M.O.s circular letter of November 12th, 1951, and felt that the Society should object to the statement that the obstetrician would undertake a follow-up with midwives. After consideration it was felt that the scheme as set out in the Ministry's circular was very little different from that agreed to by the Society and that no action be taken on this point.

226. **County Borough Group.**—The following resolution from the County Borough Group was received :—

> "That the Council of the Society be asked to consider making an approach to the Ministry of Health requesting a review of the present arrangements which cause overlap of the services provided by Welfare Authorities and the Local Health Authorities in respect of the aged and handicapped classes."

It was resolved that Dr. Llywelyn Roberts be asked to supply the Society with such information as he had to enable the Committee to consider the matter further.

*Several items in this report were referred to in the report of the Council meeting held on October 24th, 1952, min. 12. (See PUBLIC HEALTH, December, 1952, p. 46.)

227. **Industrial Health Service.**—It was reported that following the last meeting of Council an approach had been made to a borough M.O.H. to see if he would be willing to co-operate in the pilot surveys in connection with the Public Health Service. He had been unable to accept the Society's invitation and the invitation had, therefore, been sent to another M.O.H. of a medium-sized borough.

228. **Tuberculosis Regulations.**—Following a recommendation received from six M.O.H.s in the Home Counties, it was resolved to *recommend* to Council that M.O.H.s throughout the country should be asked voluntarily to continue to inform their colleagues of transfers of cases of tuberculosis.

229. **Occupational Resettlement of Tuberculous Persons.**—It was reported that the Chief M.O. Ministry of Health had stated that the Ministry did not feel that they could comply with the request of the Society that the County District M.O.H. be brought into the administrative scheme for the Occupational Resettlement of Tuberculous Persons as this matter was closely linked with Section 28 of the National Health Service Act, the administration of which was a function of Local Health Authorities.

230. **General Practice under the National Health Service.**—A verbal report on the oral evidence given by the representatives of the Society was submitted. The Society had been asked to forward to the Committee statements on the Duties of Health Visitors and on the Newcastle premature babies scheme.

231. **Maternity and Child Welfare Group.**—Following a request of the M. & C.W. Group it was resolved to *recommend* to Council that the title of the M. & C.W. Group be changed to "The Maternal and Child Health Group."

232. **Mental Deficiency Legislation.**—Members were reminded that the School Health Service Group had been asked to consider a report for the National Association for Mental Health on recommendations to be made to the Board of Control for amendments to the Mental Deficiency Legislation. The School Health Service Group did not suggest any radical changes in the report but had not dealt with all the paragraphs. The Committee agreed that the only suggested amendment to be forwarded to the N.A.M.H. was that the word "training" should be substituted for the word "education" in paragraph 14 of the report.

233. **Programme for the Session 1952-53.**—It was resolved to *recommend* to Council the suggested programme for meetings during the coming session (see Council report, PUBLIC HEALTH, December, p. 46).

234. **General Medical Services Committee, B.M.A.**—The Committee considered proposals which had been made by the B.M.A. for the amendment of the constitution of its General Medical Services Committee so that a representative of the Public Health Service be nominated jointly by the Public Health Committee of the B.M.A. and the Council of the Society instead of by the Society alone as at present. The Committee were fully in agreement with the proposal and in considering the question of the appointment of a representative of the Society to serve during the period which would intervene before the necessary amendment to the constitution could be made, it was resolved to *recommend* to Council that the person to be nominated at its next meeting should be a member of the Council who was a member of the Public Health Committee of the B.M.A. and who was also an M.O.H. of a local health authority.

235. **Candidates for Presidency of the Society.**—The Committee gave consideration of the practice of Branches of canvassing for support for their nominations for the Presidency of the Society as it appeared that occasions had arisen where a Branch's support had been pledged to a candidate before the names of other candidates were known. It was resolved to *recommend* to Council that an amended procedure be adopted for nominations for the Presidency with the effect that Branches and Groups be asked to forward to the Executive Secretary, not later than March 1st each year, the name of any member whom they wished to nominate and as soon thereafter as possible the Executive Secretary circulate the names submitted to all Branches and Groups in time for them to advise their representatives as to the course they wished them to adopt at the Council meeting to be held during the month of May, at which would be determined the final nomination to be made to an Ordinary Meeting of the Society.

236. **Health Visitors.**—A letter received from the Women Public Health Officers' Association on the question of the shortage of health visitors was referred to the Sub-committee dealing with the Training of Health Visitors.

237. **Care of Mothers and Babies and the Lying-in Period.**—It was reported that a letter dated July 31st from the Chief M.O. Ministry of Health requested the Society's comments on a circular which it is proposed to send to local health authorities regarding the need to ensure the continuity of care for women who had been confined in hospital and to clarify the statutes and rules in regard to the lying-in period. In view of the fact that comments had been requested at an early date, copies of the draft circular had been sent to individual members of the County Borough, County and Maternity and Child Welfare Groups for their comments. The draft of a reply prepared by the Executive Secretary and based on the comments received from these individual members was approved for forwarding to the Ministry.

238. **Annual Reports of M.O.H.s.**—It was reported that the Ministry of Health had consulted the Society on the then proposed circular to M.O.H.s of L.H.A.s inviting them to include in their Annual Reports in advance a section containing comments on and criticisms of the National Health Service. After consultation with the Chairman of Council and the Chairman of the General Purposes Committee, the Ministry had been informed that the Society welcomed the opportunity to make such a report. This reply was confirmed.

239. **"British Medical Journal."**—An article which had appeared in a recent *Supplement* to the *B.M.J.* was criticised by members present and it was resolved that the Chairman of Council deal with this matter on the Society's behalf.

240. **Local Government Forms.**—A letter dated August 25th from Messrs. Butterworth & Co. requested the Society to select any forms or precedents which could be included in a small encyclopaedia which was to be published containing forms for use by L.A.s. The reply which had been made by the Executive Secretary was confirmed.

241. **British Rheumatic Association.**—A letter dated August 13th from the British Rheumatic Association was received.

242. **Retrolental Fibroplasia.**—A letter dated July 3rd from the Ministry of Health requested the Society's support to a proposed follow-up to the pilot enquiry about premature babies under the weight of 3 lb. and to help to assemble data in relation to all babies born in 1952 weighing less than 4 lb. 6 oz. It was resolved that the Society support this suggestion.

243. **Abolition of the Fever Register.**—A suggestion was received from the Fever Hospital Group of the Society that the Society recommend the reinstitution of the fever register or an arrangement to ensure adequate nursing staff for this speciality. It was resolved that the Executive Secretary obtain further information for further consideration of this suggestion.

244. **Medical Examination of Canteen Workers employed in the School Health Service.**—A letter dated September 10th from a School M.O. referred to a request which he had had to carry out medical examination of all canteen workers employed in school canteens within the area of his authority, and requested the Society to give consideration to the practice of carrying out such inspections. It was felt that it was a matter for individual consideration to be given to this question by each School M.O. in the light of particular circumstances in his area.

There being no other business the meeting was declared closed at 1.10 p.m.

## MIDLAND BRANCH

*President*: Dr. H. M. Cohen (School M.O., Birmingham C.B.).

*Hon. Secretary*: Dr. W. Alcock (M.O.H., Burton-on-Trent C.B.).

The first meeting of the new session was held at Lancaster Street Welfare Centre, Birmingham, on Thursday, October 2nd, 1952, at 3.0 p.m., the retiring President (Dr. Colin Starkie) in the chair and 22 members present.

The retiring President welcomed new members to the Branch, and expressed his thanks for the assistance he had received during his year of office, and to Miss Powley, Superintendent of the Centre, for the excellent hospitality arrangements.

Dr. Starkie, in welcoming the new President, wished him a happy and successful year of office. Dr. Cohen, in taking the chair, thanked the Branch for the honour they had conferred upon him, and moved a vote of thanks to the retiring President, which was seconded and carried with acclamation.

Dr. Cohen then gave his address upon "The Reflections of a School Medical Officer." He first said how much he appreciated the honour of being elected President of the Branch and felt that the Branch had bestowed an even greater honour on his colleagues in the School Health Service.

He then briefly outlined his concept of the School Health Service, and the opportunity it provides for the promotion of health. The work is difficult but the scope is vast, yet at the present time any registered medical practitioner can be appointed a School Medical Officer, though much of the work is quite outside the province of general medicine, and calls for training in matters not included in the normal curriculum. Both in France and in the United States, however, efforts are made to instruct and select doctors for the School Health Service, and Dr. Cohen discussed the methods of selection in both countries.

In referring to mental hygiene, which is now an important part of the School Health Service, Dr. Cohen paid tribute to Dr. Auden, who, as early as 1910, was advocating in his reports the need for a psychological service.

Difficulties in assessing the general condition and nutrition of the school child were discussed, and an account given of the organised trials to assess the validity of the classification of children in the various categories.

Dr. Cohen concluded by touching briefly on the opportunities for research—in the widest sense—in the School Health Service, and recalled the statement by the late Professor Ryle of Oxford that the material in the schools for practical studies and record purposes was unique.

At the conclusion of the address, a discussion followed, in which Drs. Clayton, Griffin, and McLachlan, took part. Dr. Galloway, in proposing a hearty vote of thanks, wished the President a happy year of office, and the vote of thanks was seconded by Dr. Tabbush.

## NORTHERN BRANCH

*President*: Dr. J. B. Peters (M.O.H., Stockton-on-Tees M.B.).

*Hon. Secretary*: Dr. W. S. Walton, G.M. (M.O.H., Newcastle-on-Tyne C.B.).

A meeting of the Branch was held on October 31st, 1952. The President for 1951-52 (Dr. J. V. Walker) was in the chair and 25 members attended.

*Local Health Authority and Regional Hospital Board: Integrations of Staffs.*—The Hon. Secretary reported that the Branch's request that part-time hospital posts be made available to Local Health Authority clinicians was being taken up with the Regional Hospital Board, through the liaison committee.

*Durham C.C.: British Medical Guild Funds.*—The Hon. Secretary submitted correspondence with the B.M.A. on the help given to medical officers who had suffered financially as a result of their acceptance and subsequent withdrawal from the Durham C.C. black-listed appointments.

*British Medical Association Representatives.*—The Hon. Secretary reported that the B.M.A., North of England Branch, had nominated Dr. H. H. Goodman and Dr. G. Cormack as their representatives on the Council of the Northern Branch.

*S. Enteritidis in Mice Bait.*—Further correspondence between Dr. Forster (Chester-le-Street D.C.) and the Ministry of Agriculture and Fisheries on the use of mice bait containing organisms of the Salmonella group was considered. Dr. Forster stated that the bait was still being used by the firm concerned. It was agreed that the Branch viewed with alarm the continued use of such mice baits potientially dangerous to humans and that protest against their use be forwarded for consideration by the Council of the Society.

*Future Meetings.*—Speakers for the future meetings were discussed. The Hon. Secretary stated that the Annual Meeting would be held on November 21st and that Dr. H. Paul, Medical Officer of Health for Smethwick, had been invited for January 16th, 1953. Suggestions for future meetings included an address on "Decentralisation in Counties."

*Report of Branch's Representative on Council.*—The Branch's representative, Dr. A. S. Hebblethwaite, reported on matters which had been considered by the Council.

*Address.*—The Branch was addressed by Dr. C. A. Boucher, Ministry of Health, on "Accidents in the Home."

The Annual Meeting of the Northern Branch was held in Newcastle upon Tyne on November 21st, 1952. The President (Dr. J. V. Walker) and 17 members were present.

*District Nurse Training.*—A letter from the Newcastle Branch of the Association of Queen's Nurses was submitted asking for the support of Medical Officers of Health to a resolution passed at a recent meeting, that State Registered Nurses required additional training before undertaking district work and that there should be recognition of such training. During the discussion the opinion was expressed that the purpose of the resolution was to obtain sole recognition of the Queen's Nursing Association as the examining body in district nursing. Newcastle in conjunction with Northumberland C.C. had its own scheme lasting a much shorter period than the six months' Queen's Course, and the training given was recognised for the additional grant of £10 per annum. It was agreed that the letter be forwarded for consideration by the Council of the Society, without comment.

*Annual Report of Branch Council.*—The Hon. Secretary submitted the Annual Report for 1951-52 together with the Financial Statement which showed a credit balance of £18 7s. 4d. He pointed out that the expenditure exceeded the income obtained by grant from the Society and that further deficits could be expected in future years. The Society grant was discussed and it was agreed to recommend that the Society should explore possible economies by (*a*) publishing PUBLIC HEALTH quarterly instead of monthly and (*b*) increasing revenue from advertisements.

The Annual Report of the Northern Sub-Group of the County District Group was also submitted.

*Installation of President.*—Dr. J. B. Peters (Stockton) was then installed in the chair by the retiring President (Dr. J. V. Walker, Darlington).

*Branch Council.*—The following were elected to constitute the Branch Council: Drs. A. S. Hebblethwaite, J. Grant, E. F. Dawson-Walker, M. Hopper, J. B. Tilley, G. Wilson, E. Browell, W. J. Pierce, I. McCracken, W. Minns, J. V. Walker and M. W. Dewell, together with the President, the Vice-President, the Hon. Secretary and Drs. H. H. Goodman and G. Cormack (B.M.A. representatives).

Dr. G. H. Shanley suggested in view of the small attendances at meetings a postal vote would be a fairer method of election. The Hon. Secretary stated that the Branch By-laws stipulated election by the Branch at the Annual Meeting, but suggested that Dr. Shanley might submit a notice of motion for future consideration.

*D.P.H. Candidates.*—The Hon. Secretary stated that he had written to Headquarters suggesting a modified annual subscription to persuade D.P.H. candidates to join the Society.

*Presidential Address.*—Dr. H. J. Peters then delivered his Presidential Address on "The Annual Report of the Medical Officer of Health: Commentary in Retrospect, 1895-1924." On the motion of Dr. W. S. Walton, the President was accorded a hearty vote of thanks.

## NORTH-WESTERN BRANCH

*President*: Dr. K. K. Wood (M.O.H., Bury C.B.).

*Hon. Secretary*: Dr. J. S. G. Burnett (M.O.H., Preston C.B.).

The inaugural meeting of the Branch was held on Friday, October 10th, 1952, at Bury Town Hall, when 29 members attended.

It was resolved that Drs. G. B. Charnock, T. P. Edwards, J. D. Ingram and J. A. Tomb be nominated for honorary life membership of the Society.

It was resolved that the names of Drs. H. J. Villiers and G. Barker-Charnock be submitted as the Branch's representatives on the Tuberculosis Group Committee.

Dr. K. K. Wood was then inducted to office as President for the ensuing year and delivered an address on "Soundings for the Future" (which it is hoped to print in an early issue of PUBLIC HEALTH).

## SOUTHERN BRANCH

*President*: Dr. S. Chalmers Parry (M.O.H., Petersfield U.D. and R.D. and Droxford R.D.).

*Hon Secretary*: Dr. E. J. Gordon Wallace (M.O.H., Weymouth M.B.).

A meeting of the Branch was held at the Little Testwood House Hotel and County Club, Totton, nr. Southampton, on Friday, October 17th, 1952. Eighteen members attended.

A letter dated May 30th, 1952, received from the Assistant Secretary of the Society, was read, drawing members' attention to the payment of contributions to the Public Health Service Defence Trust. It was agreed that the Hon. Secretary should circularise members on this subject.

*Installation of President.*—Dr. N. F. Pearson, the retiring President, installed Dr. S. Chalmers Parry, Medical Officer of Health for Petersfield U.D. and R.D. and Droxford U.D., as President of the Southern Branch for the Session 1952-53. Dr. Chalmers Parry thanked the members for the honour they had done him in electing him to be their President.

He then delivered his Presidential address on "Some Medical Problems at a Camp for Displaced Persons," which will be published in a subsequent issue of PUBLIC HEALTH.

A hearty vote of thanks for Dr. Parry's address, moved by Dr. N. F. Pearson, was passed by acclamation.

After the meeting, 20 members and guests dined together at the hotel.

A meeting of the Branch of the Society of Medical Officers of Health was held at the Bitterne Park Health Centre, Southampton, on Friday, November 21st, 1952. The President was in the chair, 14 members and one guest attended.

**Tracing of V.D. Contacts**

Dr. R. M. Warren opened a discussion on the tracing of V.D. contacts and said that it was still true that the fundamental principle was not to regard the patient as a single entity but as a link in a chain; the infection had come from somewhere and might have been passed on to someone else. The incidence of these infections had diminished but it was time for redoubled efforts rather than for resting on our laurels.

The most effective method where the case was known was to issue a contact slip to the effect that the addressee was suspected to be suffering from an infective condition. Every patient was asked whether or not he was agreeable to take a contact slip and deliver it; this method proved effective in the same town but was not so practical in rural districts. If a contact slip did not prove effective one tried to get the original patient to enquire more closely as to the name and address of the suspected source of infection.

It had been found that the following particulars were helpful—where met (very frequently the name of a "pub" is mentioned), appearance of the contact, height, build, colouring and colour of eyes (an important factor in that they are one thing which did not change colour!). When all the possible information had been collated on the appropriate card this was attached to the patient's case card. These case cards were checked by the clinic almoner and contact cards noticed were removed and filed. This system worked quite well in enabling contacts to be traced.

A letter might be sent inviting the contact to attend the clinic but it must not in any way specify the nature of the infection from which the patient was suffering. Cases had been recorded where three or four letters and up to seven visits had been made before the contact had eventually come for an opinion. Reasons given for this were the fear of being found out, fear of the examination, and fear of the consequences of treatment, but personal interview with a social worker often allayed suspicion.

In a seaport the possibility of a male contact should not be overlooked; if a patient persisted in no exposure he should be asked if there had been a contact of any description.

On one occasion a patient gave a name and address and a letter was sent to this lady informing her that it would be in her interests to have a medical examination. Within hours a most indignant middle-aged couple turned up and it took about three quarters of an hour to pacify them and persuade them that this action was taken in good faith. Someone had used the address as an "accommodation address" for the evening and the original contact in this case was never found.

Legal protection for a medical officer or health visitor engaged in tracing a contact was mentioned in Ministry of Health Circular 5/48.

In a large clinic where there was a reasonable turnover there should be an almoner or a social worker appointed to the clinic in order that someone was constantly at the disposal of the medical officer, for the time factor was extremely important. This was a highly specialised branch of social work and the almoner must have a tremendous amount of patience, tact and love of her work if the maximum amount of good was to be done. An almoner got to know her district and because of this often was able to trace a contact right away. But the disadvantage was that the district got to know the almoner and a visit to a house was almost tantamount to what was done in Chicago, *viz.*, a notice on the door—"Syphilis here—keep out!"

The other alternative was to use health visitors to assist in contact tracing and to be responsible for follow-up and after-care. With a large clinic too much of the health visitors' time would be taken up. Diocesan workers can often do valuable work in connection with defaulters from the clinic but they had one disadvantage in that they would not trace contacts unless furnished with their name and address.

At least 55 separate reports were sent out from the Southampton Clinic each year as it was felt that medical officers of health associated with V.D. clinics should get a monthly report on the state of affairs, but if one clinic served quite a number of small areas it seemed a waste of time to inform medical officers that no patients had been seen from that area. If a significant number of cases came from one area the M.O.H. was notified.

Dr. Warren concluded his remarks by saying that where penicillin was given in sufficiently large doses with 24 hours of exposure, gonorrhoea never occurred, but he thought that moral problems might arise if it were generally known that oral penicillin would prevent the onset of gonorrhoea.

Almost all the members took part in a most interesting discussion following Dr. Warren's opening remarks—Dr. E. J. Gordon Wallace mentioning that he himself was protected by a resolution of his Health Committee in February, 1944, following a discussion on Regulation 33B in the House of Commons (see *Hansard* for January 20th, 1944).

On the proposition of Dr. Chalmers Parry a most hearty vote of thanks was accorded to Dr. R. M. Warren for opening the discussion, and to Dr. H. C. Maurice Williams for the excellent local arrangements which he made for the meeting.

## WELSH BRANCH

*President*: Dr. A. Trevor Jones (Sen. Admin. M.O., Welsh R.H.B.).

*Hon. Secretary*: Dr. R. T. Bevan (Dep. C. M.O.H., Glamorgan).

A meeting of the Branch was held at B.M.A. House, Cardiff, on October 24th, 1952. Twenty-four members and eleven visitors were present.

Dr. W. P. Phillips, the retiring President, thanked the members of the Branch for their support and welcomed the new President, Dr. A. Trevor Jones, installing him with the badge of office.

Dr. Trevor Jones thanked the Branch for the honour which it had conferred upon him and delivered his Presidential Address on the subject of "The Hospitals' Part in the Health Services." (Published in full elsewhere in this issue.)

In proposing a vote of thanks to the President, Dr. Colston Williams warmly thanked Dr. Trevor Jones for a fascinating walk into the past. He also related many of his personal experiences and difficulties during the growth of Hospital Services. (Dr. Trevor Jones's address is published in this issue of PUBLIC HEALTH.)

## COUNTY BOROUGH M.O.H. GROUP

*President* (1951-52): Dr. E. K. Macdonald (M.O.H., Leicester C.B.).

*Hon. Secretary*: Dr. W. S. Walton, G.M. (M.O.H., Newcastle-on-Tyne C.B.).

**Annual General Meeting and Conference, Leicester, June 27th to 29th, 1952**

The fourteenth Annual Conference of the Group was held at Beaumont Hall, Oadby, near Leicester, from June 27th to 29th, 1952. Forty-six members and five visitors attended.

The annual dinner was held in the dining hall on Friday, June 27th, 1952. The guests included Sir Ernest Rock Carling, the Deputy Lord Mayor of Leicester, the Chairman and Vice-Chairman of the Leicester Health Committee, Mr. Bishop of Beaumont Hall, and Dr. Ross, Dep. M.O.H., Leicester. Dr. Macdonald presided over the dinner and handled the week-end proceedings throughout in a most friendly and efficient manner. After-dinner speakers included Sir Ernest Rock Carling, in whimsical vein, and the chairman and vice-chairman of the Leicester Health Committee and, of course, our President.

The annual meeting commenced at 9 p.m. and proceeded until 10.10 with an interval of 15 minutes and then continued to 11.35 p.m. Sessions for papers and discussion were held on Saturday morning and Saturday evening; the last session closing at 11.25 p.m. Sunday morning was taken up with papers and discussion from 9.45 a.m. to 12.45 and the second session included a most interesting talk by Mrs. P. E. Steed, the Organiser of the Home Help Service in Leicester, who illustrated her remarks with a mannequin display by three members of her staff. The members were very impressed.

During Saturday afternoon a most enjoyable tour was arranged by the President and included a visit to Bradgate Park, where a pageant evolving round Lady Jane Grey was being presented. This was a very pleasant interlude on a fine but rather windy summer afternoon. The members were

specially impressed by the speed of the message received from the Government of that day which was conveyed by a very spectacular horseman. Tea was taken at the Leicester and County Convalescent Homes Society at Woodhouse Eaves and members were shown over the convalescent home.

During Sunday afternoon Mr. Bishop, the Warden of Beaumont Hall, conducted members round the Leicester University hostels and at 5.45 p.m. the President and Mrs. Macdonald were "At Home" in their delightful house and garden.

It seemed that a gentle zephyr of optimism and hope pervaded this meeting and that this was something different from most of the meetings held since the appointed day. The previous depressions were slowly giving way to an "anti-cyclone" filling up with resolution on the part of members to do something for their own service and for themselves. Many more contributions showed originality and some members gave reports of "unofficial trials" not quite according to the book, but nevertheless stimulating interest, and showing a sense of enquiry.

On Monday morning the members departed to their various tasks, all feeling that they had enjoyed a very instructive and most friendly week-end meeting.

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At the annual general meeting held on the evening of June 27th, the President referred to the publications issued by the Scottish Board of Health, and, in particular, to that entitled, "What Local Authorities can do to promote Health and Prevent Disease," and asked if the English Ministry of Health should do likewise. It appeared that members were satisfied with the present position.

The President welcomed the following new members on the occasion of their first visit to the Group meetings:—Drs. T. R. Roberton (Bootle), T. Ross (Walsall) and H. L. Settle (Doncaster).

The following changes in membership were announced: Retirements—Drs. W. Barr (Rotherham) and H. J. Rae (Aberdeen). Resignation—Dr. J. Tudor Lewis (formerly West Bromwich transferred to Battersea and Wandsworth Met. B's).

The election of Dr. W. Barr as an honorary member of the Group was approved with acclamation.

*Election of Officers for the year* 1952-53. The officers elected were: President, Dr. J. Stevenson Logan (Southend); Vice-President, Dr. T. Peirson (Plymouth); Past-President, Dr. E. K. Macdonald (Leicester); Executive Committee, Drs. J. Yule (Stockport), G. W. Murray (Blackpool) and J. Grant (Gateshead); Honorary Secretary/Treasurer (and Representative on Council), Dr. W. S. Walton (Newcastle-upon-Tyne).

Dr. J. M. Gibson, Chairman of the Society, made a statement on the recent activities in Whitley and other Councils regarding salaries, fragmentation and joint posts, and also the salaries of Assistant Medical Officers of Health.

On Saturday morning, June 28th, Sir Ernest Rock Carling gave a very interesting review of the work of the Central Health Services Council. He also asked Medical Officers of Health to be a little more constructive and also offer criticism together with suggestions for improvements in the present Health Services. The M.O.H. was obviously in a central position as an observer and he should perhaps be doing a little more than he actually is at the moment.

This challenge was taken up by one or two members and provoked a lengthy discussion. Sir Ernest pointed out that any major changes in constitution would involve legislation and this should be avoided if at all possible. There was plenty of room in the present framework for modification. Discussion then hinged on the correct size of an all purpose area and some of the members thought that the present Regional Hospital Board areas are too big and that the areas should be smaller and run by Area Management Committees. Dr. Kerr of Grimsby gave figures for the Sheffield Region which included 4½ million population, 30 Hospital Management Committees, 17 Local Health Committees, 14 Executive Councils and six Liaison Committees. Geographical circumstances must be taken into consideration in connection with administrative arrangements. Members taking part in this discussion included Drs. Fenton, Logan, Macdonald, Gibson, Irvine, Kerr, Gebbie and Harvey. Dr. Gibson, Huddersfield, proposed a sincere vote of thanks to Sir Ernest Rock Carling on behalf of his colleagues.

(*Continued on p.* 70)

Lord Amulree, Physician, University College Hospital, London, addressed the meeting on *"The Problem of the Chronic Sick and the Medical Officer of Health"* and mentioned that in cases of chronic sickness the patient is frightened of several things; two of them being poverty now dealt with by the National Assistance Board, and loneliness which is the cause of their being prone to illness. Twenty per cent. of people over 65 years in London were living by themselves, many in top rooms or basements because of cheaper rates. Sanitary arrangements were often very poor. Lord Amulree mentioned the advantage of visiting, including social and medical visiting. He referred to hospital accommodation, saying that many people were better off walking about than in a chair or in a bed. There were too many people in hospital who should be at home and there certainly should be a study of hospital admissions. He preferred the description long-term sick and suggested that registrars might assess whether the patient should go into hospital or not. The subjects of voluntary visitors and importance of clubs, meals on wheels service, home help service, chiropody, district nursing and physiotherapy and occupational therapy for old people were also mentioned by him.

The discussion turned upon methods of ascertainment of aged people, the importance of visiting, the use of the Health Visitor, of a laundry service and the "half way" home. An example was given of such a home financed jointly by the Regional Hospital Board and the Local Authority. The President proposed a vote of thanks to Lord Amulree for giving such an interesting account of his work in London.

On Saturday evening, June 28th, Drs. J. V. Walker (Darlington) and C. G. K. Thompson (Wakefield) read the papers published in PUBLIC HEALTH, December, 1952, pp. 33 and 35. The subsequent discussion ranged over a large field and Walker's point concerning natural boundaries and geographical districts was taken up by certain members. Some thought that there was a tendency more towards decentralisation and that the Regional Hospital Board fields at present were too large. Warin (Oxford) suggested that Local Health Authorities should join with Executive Councils as a Local Authority unit. Burnett (Preston) was more interested in the present function and not in the present structure of the Medical Officer of Health's work. He thought that a lot of the executive functions, such as domestic help and ambulances, could very well be shed, making room for further work in connection with the aged, cancer, morbidity, etc. Sir John Charles spoke at length in a helpful and constructive vein. The members showed their appreciation by their reception of his remarks and also in their own further contributions.

It was felt that the County Borough Group generally should consider the future of medical administration and it was suggested that they might consider the problem of health services for the community. It was also thought that the kind of areas should be discussed, whether geographical or ecological or having regard to social conditions and trends. The kind of executive body needed should also be considered, whether elective, selective of "joint." Also its relation to central government. Another question which was raised was who would constitute the personnel and what should be their qualifications and experience. All of these were thought to be things on which the County Borough Group should be able to formulate an opinion.

A general resolution was left to the President and Secretary to develop and the following is the result of their deliberations:

> That the County Borough Group in the light of changes and development during the last few years should set out what it considers are the main duties of the present-day Medical Officer of Health. The Secretary was instructed to invite members to submit evidence to the Executive Committee of the County Borough Group with reference to these duties of the Medical Officer of Health and to possible developments of schemes which would improve co-ordination and improvements in the Health Services generally. Accordingly evidence will be received by the Secretary for transmission to the Executive Council of the County Borough Group who will in turn pass on the findings of the Group to the Council of the Society.

The President proposed a vote of thanks to Drs. Walker and Thompson for their papers.

On Sunday morning, June 29th, Dr. J. Stevenson Logan (Southend-on-Sea) and Dr. Catherine B. Crane (York) spoke on *"Infectious Disease Control."* It is hoped that a résumé of these papers will appear in a later issue of PUBLIC HEALTH. Discussion ranged far and wide. Suggestions were put forward for notification of the first case in certain diseases. Dr. H. C. Maurice Williams proposed a vote of thanks to the opening speakers.

Mrs. P. E. Steed, Organiser, City of Leicester Home Help Service, then read the paper on the Leicester Home Help Service which has appeared in PUBLIC HEALTH October, 1952.

Members were interested in the course provided by the Education Department and in answer to an enquiry as to how it was done were told "make friends with the Director of Education!" The meeting had a short sharp debate as to who should collect money for this Service. The majority of members thought that it should be done by the Treasurer's Department and not by the Home Help Department. Queries were raised about help given to National Assistance cases. The procedure seemed to vary in different parts of the country. A night service was mentioned but obviously had not been freely adopted. The discussion also hinged on the subject of part-time versus full-time employment. Some authorities, unlike Leicester, find the part-time service more suitable in their areas. It was quite clear that some three or four authorities had extensive Home Help Services while others were more limited in their provisions.

Dr. Gebbie (Hull) proposed a vote of thanks to Mrs. Steed for her interesting paper, and to the home helps for displaying their uniform.

At the end of the morning session, the Honorary Secretary proposed a vote of thanks to the President for the most happy arrangements he had made for the week-end at Leicester. The drawing up of the programme, the congenial arrangements and the happy atmosphere bore the hallmark of what members term the "Leicester" standard. In particular, as Secretary he thought the members should know about the enormous amount of work which the President had put in to make the week-end a success. Leicester was rewarded with the usual summer weather which the Group experienced during its annual week-end. This vote of thanks was most enthusiastically received.

The President, in replying, stating that he had to thank his own officers, the Secretary and the members for the support which he had received. He had enjoyed every moment of it and in closing took the opportunity of thanking Sir John Charles, Dr. Godber, and Dr. Lilico of the Ministry of Health for coming and contributing to the discussion. The members were indeed very grateful to the Ministry's officers for their kind help and for giving up their time to come and be with the Group.

On Sunday evening, June 29th, there was a general discussion. A larger proportion of members than usual remained.

The meeting opened with a discussion on attractions for Health Visitors in the less popular areas. There were some rather awkward cross-currents at the beginning of this discussion but the President very skilfully steered his craft through the troubled waters and emerged on a fair course. Dr. Thompson (Wakefield) made out a very good cause for the less attractive areas but it was generally felt that until more health visitors were available any special attraction in any district would merely rob another district. Of the members present 17 found difficulty owing to shortage of health visitors, another 17 had had to offer bursaries for training in order to recruit and eight were up to their normal health visiting establishment. The meeting agreed that the Society should be asked to consider the whole problem of recruitment, training and supply of health visitors in view of the shortage of Health Visitors now facing many of the County Boroughs. The resolution passed by the Group on this subject has since been published in the proceedings of the Society's Council.

Dr. Rennie (Carlisle) raised the question of transferable deaths from the Registrar-General with special reference to deaths of old people in hostels and homes outside their area.

Dr. Parkman (Hastings) raised the question of the name of this Group meeting. It was resolved to leave this matter over until later.

Dr. Hebblethwaite (Sunderland) mentioned an offer of his local hairdressers to give out lotions for the authority where infestations have been found. This involved a discussion on the possibility of reviving the Scabies Order.

Dr. Dodd (Nottingham) told of the activities of the Health Department in Nottingham in securing the erection of houses for tuberculous cases. He also referred to the increasing expense in Nottingham of the Home Help Service.

Members taking part in the discussions included Drs. Alcock, Burnett, Parkman, Rennie, Fenton, Burn, Logan, Crane, Dodd, Soothill, Hebblethwaite, the President and the Secretary.


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